DOCUMENT RESUME

ED 261 800 PS 015 361

AUTHOR Sloane, Risa
TITLE Development and Implementation of a Study Guide for a Program of Prenatal, Child Development and Parenting Information Designed for the Practitioner's Use with the Pregnant Teenager.
PUB DATE May 85
NOTE 196p.; Ed.D. Practicum Report, Nova University.
PUB TYPE Dissertations/Theses - Practicum Papers (043) -- Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS *Adolescents; Birth; Child Development; Child Rearing; Counselors; Curriculum Guides; Early Parenthood; *Instructional Materials; *Parenthood Education; *Parenting Skills; Pregnancy; *Pregnant Students; Resource Materials; Social Workers
IDENTIFIERS *Prenatal Care

ABSTRACT

The goal of this practicum project was to develop a curriculum resource guide for social workers or counselors that addressed the particular needs of pregnant teenagers wishing to continue attendance at their regular schools. The guide, titled "A Facilitator's Guide for Pregnant Students," provides practitioner information concerning prenatal care and childbirth, the newborn child, and child development and parenting, as well as resource lists of films, filmstrips, visual aids, books, manuals and pamphlets, and student handouts. Field testing among practitioners and administrators/directors indicated that the guide was well received and considered valuable. Survey instruments and the guide are appended to the practicum report. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED261800

PRACTICUM REPORT

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

X Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

Center for the
Advancement of Education
Ed.D. Program

Development And Implementation Of A Study Guide For A Program Of Prenatal, Child Development And Parenting Information Designed For The Practitioner's Use With The Pregnant Teenager

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Risa Sloane

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

PS 015361

3301 College Avenue
Fort Lauderdale, Florida 33314
305/475-7300

NOVA UNIVERSITY

DEVELOPMENT AND IMPLEMENTATION OF A STUDY GUIDE FOR A PROGRAM OF PRENATAL, CHILD DEVELOPMENT AND PARENTING INFORMATION DESIGNED FOR THE PRACTITIONER'S USE WITH THE PREGNANT TEENAGER

by

Risa Sloane

Cluster 8

A Practicum Report Presented to the Ed.D. Program
in Early Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

May, 1985

TABLE OF CONTENTS

TABLE OF CONTENTS ii

LIST OF TABLES iii

LIST OF FIGURES iv

ABSTRACT v

Chapter

I. INTRODUCTION 1

Explanation of Writer's Role/Work Setting 1
Description of the Community and Socio-Economic Factors 4

II. STUDY OF THE PROBLEM. 6

Description of the Problem 6
Documentation 7
Analysis of Possible Causes 9
Relationship of the Problem to Literature 12

III. ANTICIPATED OUTCOMES AND EVALUATIONS INSTRUMENTS 17

Statement of General Aims or Goals 17
Terminal Performance Objectives 17
Description of Evaluation Instruments to be Administered 19

IV. SOLUTION STRATEGY 21

Discussion and Evaluation of Possible Solutions 22
Description of and Justification for Solution Selected 24
Calendar Plan for Implementation of Selected Solution 27
Report of Action Taken 28

V. RESULTS, CONCLUSIONS, RECOMMENDATIONS . . . 33

BIBLIOGRAPHY 50

APPENDICES

A. Practitioner Survey 54

B. Expert-Panel Survey 57

C. Resource Guide for Pregnant Teenagers 59

LIST OF TABLES

Table

1 Practitioner's Survey 35

2 Expert-Panel Survey 40

LIST OF FIGURES

Figure		Page
3.0	Question 10 - Practitioner Survey	36
4.0	Question 9 - Practitioner Survey	38
5.0	Question 5 - Expert-Panel Survey	39

ABSTRACT

Development and Implementation of a Resource Guide for a Program of Prenatal, Child Development and Parenting Information Designed for the Practitioner's Use With the Pregnant Teenager. Sloane, Risa 1985 Practicum Report, Nova University, Ed.D. Early Childhood Program
Descriptors: Pregnant Students/Unwed Mothers/Parenthood Education/Childrearing/Teenagers/Adolescents/Family Planning/ Pregnancy/Sex Education/Parent Attitudes/Prevention/Prenatal Influences/Parenting/Resource/Secondary Education/Early Parenthood/

The problem addressed by this practicum was a need for readily available resource material to be used by the practitioner when working with the pregnant teenager. The teenager remained in the regular school setting and was limited in contact time (usually once a week) with a social worker or counselor assigned to provide her with prenatal health care information. To facilitate this process, a comprehensive guide for the practitioner was developed. This information was designed to cover areas of labor and delivery, child development, child care and parenting. It was also structured to provide information easily, and provide learning strategies for low-achievers. It was predicted that 75% of those practitioners surveyed would find the information appropriate to use with the pregnant teenager and facilitate the practitioner's ability to impart that information. It was further predicted that 75% of the practitioners would rate the guide with a positive response. It was further determined that 75% of the supervisors/directors exposed to the guide would recommend its use.

In all cases, objectives were met. Actual percentages exceeded predictions and in many cases equalled 100% positive responses. It was concluded that a resource guide of this nature proved to be a valuable asset and could easily be incorporated into a program for pregnant teenagers in the Broward County School System.

CHAPTER I

INTRODUCTION

Explanation of Writer's Role/Work Setting

This writer has been employed by the Broward County School Board of Florida as a learning disabilities teacher at Dillard High School for the past four years and prior to that, worked with kindergarten and early elementary school children who were also learning disabled. During that time, this writer was mandated a transfer by the School Board into the high school setting.

Dillard High School has a strong, rich history. It is one of the oldest high schools (76 years old) and stands as a beacon of pride and accomplishment for the black community of Fort Lauderdale. Although it is predominantly black and stands in an economically depressed area, white students are bussed to Dillard. Dillard boasts of having a large vocational component as well as acting as a magnet school for the only performing arts center for all of Fort Lauderdale. This center has provided the students with an exceptional education, as well as providing the community with cultural enrichment by opening up all its performances to the public.

The special education department includes approximately 180 part-time or full-time students. It is divided into the exceptionalities of specific learning disabilities,

emotionally handicapped, educationally mentally handicapped and gifted.

As a learning disabilities teacher at Dillard, this writer conducted five class periods a day, working with grades nine through twelve and dealing with reading and math abilities as low as pre-primer levels. Other areas of role differentiation by this writer involved the coordination of the curriculum and annual review meetings with the staff, school psychologist, parents and social worker in evaluating each student's performance.

It had been during this setting that this writer had come into contact with a number of pregnant students. The number of pregnant teenagers has been on a steady rise since the early 1970's and has been widely acknowledged as a major problem throughout the nation (see Chapter II).

The setting for this practicum included sites around the county, such as Cyesis and Broward General Hospital as well as the enlistment of various social workers, counselors and health teachers assigned to Dillard and other county schools in determining the effectiveness of the program guide developed. Besides the public sector, this writer had enlisted the expertise of Henderson Clinic, a federally funded, but privately operated counseling service. Henderson Clinic had been in existence for 30 years. Their HAPP program (Henderson Adolescent Pregnancy

Program) had been in existence for three years. Ms. J. Wagemann, who directs this program, had also offered access to her population for the evaluation of the guide.

The role of this writer was to research and develop a program guide which specifically tapped into the needs and interests of the pregnant teenager, while taking into consideration the limited academic level of many of these students. This writer also developed an evaluation survey that was to be filled out by the various social workers, medical personnel and counselors who had access to this guide in order to determine if their needs (as expressed in interviews in Chapter II) had been met. A parallel expert-survey instrument was also developed to assess the value such a guide would have in allied departments around the county. The utilization of the program guide was the role of those social workers and counselors involved in the programs. Some of the social workers were based at the Cyesis Center--a Broward County School which had been specifically established to provide a regular education to pregnant teenagers who did not wish to go to their home-based school.

Description of the Community and Socioeconomic Factors

Fort Lauderdale is situated on the Gold Coast of Florida. Due to its beautiful beaches and warm climate, it has attracted tourists as well as retirees throughout the year.

Within the last fifteen to twenty years there has been a population boom. Many people from the northern and midwestern states have made Florida their home. Due to the increase in population, there has been a greater need for a variety of social services. Fort Lauderdale's population is a mixture of both young and old, black and white with a recent increase in Hispanic.

Although there is a varying degree of socioeconomic levels within the city of Fort Lauderdale, many of Dillard High School's students remain in the lower economic quadrant of the population. This is mainly due to the fact that the majority of Dillard High School's population is black.

It had been determined that such students would naturally seek access to public county health services such as H.R.S. and federally funded clinics such as Henderson, which offer them free or payments on a sliding scale. It was further determined that such students would tend to drop out of school, continuing the poverty cycle.

The epidemic of pregnancy among teenagers is not limited to the black population--it cuts across economic

and racial lines. But due to the accessibility of Dillard High School and the Henderson Clinic for this writer, the majority of students in this study were expected to be black and reflect a lower socioeconomic background.

CHAPTER II

STUDY OF THE PROBLEM

Description of the Problem

Of the three social workers who dealt with pregnant teenagers within the Broward school system, each had come in contact with approximately 100 students apiece. These social workers had visited eight schools a week, at which time they attempted to counsel these girls in pre-natal health care, child development and parenting; as well as general emotional support and monitor any family problems which had arisen.

Although there was more of a comprehensive curriculum within the health classes at the Cyesis Center (a center for pregnant students who did not wish to attend their regular home-based school), none such curriculum existed for those students who remained at their regular school. It was left to each social worker to determine what information got to these pregnant teenagers (on an individual basis) and whatever the students may have picked up within their regular classes at school.

The health classes at the regular schools were attended by both male and female. Although the subject matter may have touched upon such things as birth control, family planning and child development, these courses were not specific

to the needs of the pregnant teenager and did not allow for varying degrees in academic achievement. To date, special education students had to take regular classes in health education. The pregnant students within each regular school tended to stay isolated from one another in terms of dialogue, direction, information and classes that would be specific to their problems.

The problem to be addressed in this proposal was how could the school system facilitate an adequate in-school program which addressed the specific needs of the pregnant teenager who wished to remain in her regular home-based middle or high school.

Documentation

Informal interviews were conducted with various individuals actively involved with the education of the pregnant teenager in Broward County.

The first contact was with Diane Scalese, Administrative Director of Health Education of the Broward County Schools. She acknowledged to this writer that there was a definite need for a concise, in-school program for pregnant teenagers. At this time, however, she stated that the lack of adequate funds was one of the system's main reasons for not launching a full-scale attempt at addressing the problem.

In an interview with Jean Waggman, director of the Henderson Adolescent Pregnancy Program, Ms. Waggman stated

that if "more was done in the schools, we could accomplish so much more." Ms. Waggman comes in contact with approximately 110-120 pregnant teenagers each year.

Ms. Patti Dolch, social worker for the county based at the Cyesis Center, stated that the students at the center seemed to respond better than those at the home-based schools, because they were able to get their information within a classroom setting which allowed for more dialogue and was specific to their needs. They were less isolated. This social worker also acknowledged that there was a need to lower the reading and comprehension level of the material given because there was a definite mix between the average students and the slower ones, making it harder to work with them.

Mary Williams, social worker assigned to Dillard, reiterated that contact with these students remained at once a week for one period and that many of these pregnant teenagers were not even enrolled in health classes at the time prior to or during their pregnancy. Thus, any information given to them was of a short duration and only through contact with the social worker.

Both social workers said that they would welcome any added materials, guides or programs that would help them succeed with their jobs. They had no formal curriculum, but felt that information or a curriculum addressing some

special needs areas should include human growth and development and parenting.

Analysis of Possible Causes

The problem of teenage pregnancies has continued to escalate despite the numerous attempts by local and national governments to incorporate educational programs in the schools. It is important to understand the correlation of increased pregnancies with the need to provide adequate programs for the number of pregnant teenagers who attend school.

Illegitimate births in 1979 increased by 10% since 1978 (see Time Magazine, Nov., 1981). These teenage pregnancies had resulted in an increase of high school dropouts, premature births, handicapped or at-risk infants, as well as increases in neglect or child abuse due to the immaturity, isolation and lack of family support given to teenage mothers.

Sociological trends had included the influence of societal and peer pressure to engage in sex at an earlier age and the increasing desire to "keep" the baby rather than give it up for adoption. Professor Anastasiow, in his article for the Council for Exceptional Children had stated that lack of awareness and immaturity on the part of the teenage mother could not provide the social climate necessary for normal development.

Obviously, these problems produced stress on the governmental bodies which provided aid (financial or otherwise).

Sociological studies had speculated that the desire for teenage girls to keep their babies was influenced by the fact that society no longer threw the pregnant teenager out of school. Also, there had been a decline of the social stigma of the single parent (brought on by increased divorce rates) although single parenting was not uncommon among the black culture.

Other causes included the psychological need to fill their life with someone to love or to "play" mother without understanding the responsibilities that accompanied it. Teenagers had been encouraged by peer approval, which looked upon the pregnancy as a status symbol.

The need of a good solid foundation in prenatal care, child growth and development and parenting for the teenagers was obvious.

In an article in the Miami Herald dated December 18, 1983, Shelby Miller, a research associate at the Child Welfare League stated "many programs now just help you right through your delivery and then they stop. You're left with a baby and a whole new set of responsibilities and not a whole lot of help."

Attempts by Broward County to effectively treat the problem of teenage pregnancy had not always been successful. First, students were kept in separate facilities (Cyesis Center). This center closed, keeping only a

satellite at the Seagull School for the handicapped. This was to provide for middle school students who tended to use the center even though high school students had the option of staying at their own high schools.

It had been stated in an article by Marc Fisher in the Miami Herald (Dec. 5, 1982) that there had been poor availability of support systems including social workers and parenting curriculum for students.

In the past, Cyesis housed under 400 students although Broward records showed 1,700 teenage births during 1980. Thus, such information supported the concept that the needs of many teenage mothers were not being met by school programs.

Sociologically, the issue was a socieconomic one. Those who could afford abortions or who had supportive families could survive the episode. Others could not or were ill-prepared. An underlying power conflict was expressed by the quote of the executive director of planned parenthood in referring to the "school people" who refused to address this issue head on. Mirow felt that "Broward County is light years away from producing proper in-school programs." (Miami Herald, Dec. 5, 1982)

Thus, the cause of this problem stemmed from many sources. First, there was the escalation of teenage pregnancies. There was the desire of said students to keep their

babies and remain at school. Next there was the lack of family support (emotional and financial) and the lack of educational support of Broward County due to limited budgets inertia and/or a firm commitment to the problem. This lack of commitment was seen in the ratio of students to social workers. Not all students were enrolled in a health class and these health classes did not address the specific problems of the pregnant teenager. Therefore, these issues produced or "exhasserbated" the problem of providing an educational component that addressed the needs of pregnant teenagers who remained in the mainstream of the school system.

Relationship of the problem to Literature

The needs for prenatal in-school programs are paramount. In an article in the Miami Herald, April 14, 1984, Myra Lentz, Health Department Administrator, stated that the Health Department spends about 1.5 million dollars a year on prenatal programs "but it cannot reach all the low-income women who need its services."

In a statistical report from the Children's Defense Fund this year, some important facts had been stated. First, the group contended that "American children are more likely today to suffer death and sickness, hunger and cold, abuse and neglect...than three years ago." The

report also stated that one in five children (13.1 million) is poor." Poor children have an increased chance of serious health problems because their mothers receive inadequate prenatal care." (USA Today, March, 1984)

The number of live births to 16 to 17 year olds had increased 25 percent between 1960 and 1973 from 163,000 to 204,000. Births to young girls under sixteen increased 80 percent from 26,000 to 48,000 during the same period (Stickle and Ma, 1975).

The numbers of teenage pregnancies had so increased as to indicate that if trends continued, four out of ten girls would become pregnant during their teens (Kotulak, Miami Herald, Oct. 4, 1981).

The pregnancies of many of these women were most often associated with high risk factors. Such factors included prematurity, low birth-weight babies, and delivery complications; all of which could produce conditions of later physical, emotional and intellectual impairment (Anastasiow, 1977).

The causal increase of teenage pregnancies was seen in two areas. The first was the drop in the age for menarche (menstruation) from 1900 at age 14.2 to today at which it has been estimated at 11.8 years (Eskin, 1977).

The second area was the change in society's view of premarital sex. Young people had become more sexually

active at an early age. Diepold (1976) had estimated that 32 percent to 68 percent of adolescent girls had experienced coitus before age 18.

Due to inexperience, lack of maturity and the fact that many teenagers come from low economic status, a burden had been placed upon social agencies. "The social costs of the teenage pregnancy epidemic are extremely high. With small children to care for, few skills, little education and often no husbands, many teenage mothers must go on welfare." (Kotulak, 1981)

The teenage mother was not always in a position to provide positive child care. If the mother came from a lower socioeconomic strata, she had not had an opportunity to learn about proper nutrition, medical care or child-rearing practices. Her only opportunity for such would have been the contact she had within the public school system. "Research on overcoming the effects of perinatal stress suggests that the most important variable is the child care provided by the mother." (Bell, Casto and Daniels, 1983)

It was noted in a study done by Coles (1971, Vol. II) that these high-risk mothers tended to have their first baby early in life (10 to 15 years of age), produce more babies (8 to 10) than the average woman and continue to have children beyond the normal child-bearing age (35 to 40).

This data and others showed that children of such mothers were "smaller at birth, die more readily and are generally in poorer condition in infancy...their illnesses more frequent, more severe. Their nutrition is negatively influenced by their mother's health, age, her income level, her education, her habits and attitudes." (Birch and Gussow, 1970)

Thus, one could conclude that a high-risk mother produced a high-risk infant. In a New York study it had been ascertained that such young mothers tended to receive prenatal care later and had fewer prenatal checkups. Data suggests that in that study 73 percent of the black families were high risk (Stickle and Ma, 1975).

Therefore, the increase of teenage pregnancies, compounded by a reduction in the young mother's economic stability produced conditions that affected the infant. These effects or perinatal stress were the result of immaturity on the part of the mother and produced a high-risk infant. It had also been determined that "the most lethal of childbirth conditions (anoxia and breech birth) were considered minor compared to the negative effects of a mother's child-care techniques" (Broman et al., 1975).

Such students gained whatever expertise in the area of prenatal health and child care from their contact with the school. Thus, if we failed to provide for this ever

growing need, we failed not only the young mother-to-be, but the infant and ultimately society, which must deal with the results.

Most recently there had been a push or commitment by the government for improving education (New York Times "Spring Educational Review," April 14, 1985). It was stated that although millions of dollars had been slated for quality education, teenage mothers and minorities were being excluded as recipients. This would further support the fact that a need to provide programs for such teenagers definitely exists.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Statement of General Aims or Goals

The goal of this practicum was to develop a resource program guide which would address the specific needs of the pregnant teenager who wished to remain in her regular school. The guide would provide supplementary information, educational objectives, list available materials and sample lessons in order to aid the social worker or counselor in her job to supply prenatal health care, parenting information and concepts of child care and development to said teenager. Such a curriculum guide would give formal direction for the social worker or any individual who would have had contact with pregnant teenagers, representing that student's primary contact for prenatal information.

Terminal Performance Objectives

The following goals were projected for this practicum:

1. After accumulating information and research on programs for pregnant teenagers, this writer will compile a curriculum program guide which will address the specific needs of the pregnant teenager and include sample lessons and strategies needed to adjust comprehension levels for the learning disabled or slow learner.

2. After the implementation of the program guide for pregnant teenagers 75% of the social workers and counselors who use it will find that the structure of the material makes it easy to use.

Assessment: Evaluation Survey

3. Given a questionnaire survey about the program guide, 75% of the social workers and counselors using it will positively evaluate the guide.

4. After social workers, counselors, etc., use the sample lessons for lower academic levels included in the guide, 75% of them will find that their ability to transmit the information to such students has been made easier.

Assessment: Evaluation Survey

5. After reviewing and using the guide, 75% of the practitioners will feel that it contains the information needed for their work with pregnant teenagers.

Assessment: Evaluation Survey

6. Seventy-five percent of the supervisors and directors in related fields but outside the high school setting will positively recommend this guide as a resource for working with pregnant teenagers.

Assessment: Expert-Panel Survey

Description of Evaluation Instruments Administered

The instruments used were created by this writer to directly coordinate with the guide and the objectives to be assessed. The initial evaluation instrument was a Likert Scale (strongly agree/strongly disagree). This type of assessment was initially developed in the early 1930's by Dr. Rensis Likert. It was used as a technique for measuring attitudes and did not need a range of negative items. This benefit explained its popularity in industrial applications. The Likert technique consists of a series of statements to which an individual responds, using a 5-point scale of possible choices. Such statements (strongly-agree/strongly disagree) can be expanded to seven or more steps. Modifications included the forced-choice Likert approach with no neutral category and a faces approach, developed by T. Kunin, in which faces scaled from a smile to a frown were used for illiterate subjects. The reliability of the Likert Scales are in the 0.90 range.

This writer selected the Likert scale because judgment of a particular material's appeal and usefulness was felt to be subjective in nature. By keying into particular areas of the guide, a cummulative effect would result in a response directly correlated to the objectives.

One evaluation survey was created to retrieve responses

from the practitioners who used the guide and were in direct contact with the pregnant teenagers.

The second evaluation survey used the expertise of a number of supervisors and department heads who were in allied disciplines but did not necessarily have direct contact with pregnant teenagers.

This survey was to determine the extension of the guide as valid for the proposed area and beyond.

The Likert Scale afforded this writer a breakdown of specific areas within the guide and allowed for the interpretation of specific factors such as color-coding as a means to determine the easy usage of such a guide.

The evaluation process also provided for open-ended comments including recommendations for changes, additions and future use.

This aspect of the survey provided the key to the interpretative analysis in Chapter V.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

There were a variety of approaches to solving the needs of the pregnant teenager. These could have involved individual programs within the public schools. They could have been classes given at the schools as part of their health credits or requirements for graduation. Solutions included isolation in special centers or special schools designated for the pregnant teenager or simple individual counseling which was provided by the guidance department of the school system or the county social worker.

The Children's Aid Society of Utah had been active in adolescent pregnancy programs for many years, providing comprehensive counseling and placement programs. It had had difficulty, however, in offering long-term programs for the at-risk mother and child, due to financial burdens. Yet it had been determined that parents could serve as effective teachers for their children (Stone, 1975).

A project instituted by the Early Childhood Research Program at Utah State University called "The Single Parent Project," focused on a balanced integrated intervention for both mothers and children (Bell, Casto, etc., 1983).

Techniques of weekly group sessions including a variety of materials were used.

It was determined that use of such a program would be helpful after the delivery of the baby, but would not be feasible while the student was pregnant and still in school.

Another solution to the problem was the establishment of a school for pregnant teenagers. Findings had shown that the Continuing Education for Young Women program of the Kalamazoo (CEYW) showed positive effects. Results indicated that the program encouraged high school completion and avoidance of repeated pregnancies (Sung, K, and Rothrock, D., 1980). But some critics had argued that young mothers attending the school would be isolated from their peers making it difficult to reenter school after delivery. Another consideration stressed, was the high cost of special classes. Some administrators even voiced concerns that such special programs might become so attractive that it would "encourage" teenage pregnancy.

As was stated in Chapter II, Broward County had already initiated an individual school (Cyesis) but due to a variety of administrative reasons (perhaps financial) the program was cut, leaving a small remnant housed in a school for severely handicapped children. Such a cut limited the services available to those students and certainly did

nothing for the pregnant teenager who still remained in the regular school setting.

This writer had an opportunity to approach the adult vocational director of Broward County Schools, Linda Lopez.

She had recommended the exploration of a program they had been using with Broward General Hospital called "Amanda the Panda" by Dr. Glen Rediehs (1979). The program involved a series of informational pamphlets on child care which was sent to coincide with each month of life after the birth of the baby. It covered the baby from newborn to one year of age. The program also included optional "Panda Parties" which were get togethers or "rap" sessions.

This writer contacted Dr. Rediehs and found that the information was not written with the pregnant teenager in mind and also had an approximate reading level of fifth grade. This would exclude any slow learners or students from special education classes. Another problem with the program was that it was limited to post delivery of the child. Thus it could not be used, as it stood, for the in-school pregnant teenager.

Other options opened was the use of home-visits as described in an article by Mary Cappleman (Cappleman, M., 1982), in which the establishment of intervention techniques moderately increased test scores on the infants

and established positive interaction between parent and child. Again such a solution would prove an advantage after the birth of the child.

As stated by Diane Scalese (Chapter II), financial budget considerations had been the major limiting factor in incorporating a special program for pregnant teenagers in the high school health curriculum.

To insert any type of program in the general health classes would have been also a poor solution to the problem. These classes were opened to the general student population and involved both male and female students. Such arrangements encouraged inhibitive behavior on the part of the pregnant teenagers who would have been reluctant to voice their concerns. It would have also encouraged lack of interest on the part of those students who would not identify with such needs.

Thus, none of the above strategies could have been used as a solution to the problem stated in Chapter II.

Description of and Justification for Solution Selected

Most research had indicated the need for such programs (see Chapter II). Research on overcoming the effects of such a pregnancy suggested that the child care provided to the infant was the most powerful indicator for success (Broman, etc., 1975). Therefore, most programs should

have included aspects of child development and parenting in its body.

The solution should have dealt with the immediate reality. This reality reflected pregnant students who had contact with a social worker once a week as a means to gain support and information on their condition.

In an article by Carol Smith (Smith, 1982) the position advocated to serve such a need was the development of resource rooms in the secondary schools to serve the health and social service needs of pregnant teenagers.

This setting is exactly the one that existed at present. The important missing component was the encouragement of more group sessions and the availability of program material given in a structured manner for the social workers who deal with these students.

It had been previously researched that group interaction could be a significant learning experience (Ricciuti and Willis, 1980). Therefore, included in the solution was a component that involved group interaction as well.

The solution to the problem (see Chapter II) was the development of a curriculum resource guide which provided a structured outline of objectives and information on such stated needs as prenatal care, child care and development and parenting.

The FEED (Facilitative Environments Encouraging

Development) program is a middle-grade curriculum experience that focuses on assisting young people in learning about child growth and development of infants and preschoolers prior to becoming parents. Dr. Nick Anastasiow's (N. Anastasiow, 1978) research had stated that it has been successful in helping students clarify their attitudes and help build an informational base for good caretaking.

Contrary to previous understanding, the perinatal stress conditions which many times accompany a teenage pregnancy could be overcome by the implementation of basically sound child-rearing practices.

The guide proposed for this practicum incorporated many of the objectives expressed in such programs as FEED, Amanda the Panda, and others (e.g. Teens Parenting, J. Lindsay, 1981).

It incorporated a structured outline that provided the social worker or counselor with:

1. annotated bibliographies (books-visual aids)
2. pamphlets, booklets, etc., for students
3. handouts for lessons
4. lists of resources available
5. student activities
6. curriculum objectives that covered the specific developmental patterns of children ages 0-5
7. methods of stimulating the emotional, cognitive and physical growth of the child

8. curriculum objectives that covered topics of parenting, discipline and problems related to single parenthood

9. sample lesson ideas which included adaptions for the slow learner or learning disabled

10. curriculum objectives that encouraged group discussions and group projects

This guide, although structured in nature freed the social worker in that she was able to apply any part or all that was included in the guide. The practitioner selectively used only what suited the needs of her student. She could have used the guide in any order. Each component was utilized separately.

The purpose of this guide was to facilitate the ease to which the social worker, counselor or teacher addressed the needs of the pregnant teenager who remained in the regular school setting.

Calendar Plan for Implementation of Selected Solution

1. The implementation of research devoted to information gathering for preparation of the written guide included the months of May and June, 1984.

2. The actual development of the guide and surveys took approximately four months, from July through September, 1984.

3. Implementation of the finished guide by the social workers and counselors was limited from a three to four-month

period. This was done because students used in the population may have been at various states of pregnancy.

4. The last months were to be devoted to administering the survey and collecting the data.

Report of Action Taken

The action taken could be divided into three major parts. The first section was the writing and editing of the program guide. The second, was to establish contact with the population and introduce the guide. The third was the collection of the data.

Although actual pregnancy guides geared to the intended population of teenagers were limited, this author did find an abundance of material on the actual content subject matter. Organizations such as PACE and CEA, along with the March of Dimes, were extremely helpful. This author was able to obtain many pamphlets which were subsequently sited as sources in the program guide and included as "handouts" when the guides were distributed to the population.

As with any project of this magnitude, the major effort was related to editing information and limiting, to some extent, what could be included in the guide.

This author found that certain sources, such as FEED, proved to be less beneficial than other sources. While FEED is an excellent program and supplied a variety of

resources for the guide, in actuality it focused more on changing attitudes toward the handicapped child. Thus, as with others, it provided only one phase of the information.

It was expected that most sources reviewed did not cover a cross-section of information but concentrated on one aspect. A bibliography was not included in the actual guide at the time of printing but was to be included as references for the practicum itself.

The second section of the implementation process proved to be the most difficult. A meeting was set up with the supervisor of visiting teachers and the social workers who had contact with the hundreds of pregnant teenagers in the county. The other 27 visiting teachers acted as a referral service and as previously anticipated, could not be used in the study. Of the three, one was found to be on maternity leave. The supervisor informed this author that the county was in the process of looking for a replacement. Because of the overload, it was determined that the implementation of the second phase might be postponed to January. In general, the visiting teachers were receptive and indicated a desire to participate.

Obviously, this author had to make an effort to broaden the numerical base of the population. Contact was made with Henderson clinic and a meeting was arranged to

discuss the study. This resulted in four more subjects.

This author met with the supervisor of health education in the Broward County Schools and referrals to various sources provided many more subjects. A wide and diverse section of population resulted from these efforts and the guide was now being utilized in a variety of departments including H.R.S., patient educators at Lighthouse Point Hospital, Haitian Outreach Programs in Broward General Hospital as well as the guidance department of a middle school and the health classes of Dillard High School.

The shift in population, although a problem in the beginning, turned out to be an advantage in providing a varied population. This author would recommend that an individual preparing a study would allow for options with the understanding that a population shift could conceivably occur.

Administrators play an important role in determining policy and encouraging in what direction a particular department will take. It was important to see how these supervisors and directors viewed the potentiality and usefulness of the resource guide. Many of these administrators also had contact with the pregnant teenager. As a result, two surveys were written. One concentrated on the practitioner, while the second survey evaluated the responses from the supervisor or director. Such information

was important in determining the state and national implication such programs might have when further developed.

This author believed that personal contact with each member of the population was essential to establish rapport and provide enthusiasm needed for the project. A telephone call or letter does not elicit commitment. This was a time-consuming procedure because the location of each subject was scattered throughout the county and contact could only be done after school hours.

The use and rationale of the guide and study was briefly reviewed with them. A variety of booklets, pamphlets and books accompanied each guide as a means of expediting the process so time, otherwise spent on procuring the booklets, would be eliminated. It also established a sense of goodwill. Each subject appeared to be pleased that they would be able to keep the guide and handouts from the study.

The instructions to each subject required them to read and utilize the information in the guide in any order they felt was applicable to their situation. This was specifically stated because the practitioner would be in contact with mothers-to-be at different stages of pregnancy. The approximate time frame extended to three months.

Realistically it was not feasible to follow up each subject on a scheduled basis because many of the practitioners traveled to different locations and were not easily accessible.

This author did make sure that each subject was contacted at least once to check on her progress. However, this had to be done in a more spontaneous manner.

It was necessary during the last section of implementation to make telephone contact numerous times. The initial contact was to prepare the subjects that the survey would have to be completed within a certain time. The follow-up contacts were used to provide extra copies of the surveys if they were needed or to provide self-addressed envelopes to ease the return process. This author had to personally go to some of the sites to pick up that information, while those within the Broward school system merely placed the surveys in the intra-school pony.

One very pleasant addition to the study was the enthusiastic response of the subjects. Many of them not only offered the names of materials, books and films recommended for additions to the guide, but in some cases the actual book or article was given or sent to this author.

CHAPTER V

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

Results

The problem to be addressed by this practicum was the need to provide concise and readily available resource material to aid a practitioner in educating the pregnant teenager. This teenager remained in the school setting and followed the regular curriculum needed for graduation. The only contact with prenatal information about labor, delivery, birth, childcare and parenting, was from the social worker, guidance counselor, or less common, the health teacher. Contact with these information-givers was infrequent and was restricted to approximately once a week.

To facilitate this process and insure that the needs of the pregnant teenager were being met, a resource guide was developed. This satisfied the goal of the first objective which was to accumulate material that would address those needs and provide a comprehensive guide for the practitioner that touched upon all those areas previously discussed.

The compilation of material used in the resource guide was identified as meaningful in Question #9 of the Practitioner Survey which stated: "The guide covered the

information I needed in order to work with the students." Out of 11 surveys, 10 marked either "Strongly Agree" or "Agree" (refer to Table 1). This established validity of information incorporated in Objective One.

The goal of Objective Two was to facilitate the job of educating these pregnant teenagers. The guide was to provide easy usage and enable the practitioner to reach for information needed at her fingertips.

Questions one, two and eight of the Practitioner's Survey covered these areas:

Question one stated: "The material was easy to read and understand."

Out of 11 surveys, 11 checked either "Strongly Agree" or "Agree" (refer to Table 1).

Question Two stated: "The introduction gave a clear understanding of the rationale of the guide." Out of 11 surveys, 11 chose either "Strongly Agree" or "Agree" (refer to Table 1).

Question Eight stated: "The color-coded pages helped me find the information I needed quickly." Out of 11 surveys, 11 marked either "Strongly Agree" or "Agree" (refer to Table 1).

Objective Three stated that 75% of the social workers, counselors, etc., will "positively" evaluate the guide. This author identified "positive" as responses in the "Strongly Agree" or "Agree" category. All statements in the survey were written in the positive form.

TABLE ONE

PRACTITIONER'S SURVEY

Strongly Agree 1
Agree 2
Uncertain 3
Disagree 4
Strongly Disagree 5

Surveys	Numbered Questions									
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
01	1	1	2	2	1	1	3	2	1	1
02	1	1	1	4	2	1	3	2	1	3
03	1	1	1	3	1	1	3	1	1	1
04	1	2	1	2	2	2	3	2	2	2
05	2	2	2	4	2	2	4	2	2	3
06	2	2	2	2	2	2	2	1	1	1
07	1	1	2	1	1	1	2	1	2	1
08	1	1	2	1	1	1	1	1	1	1
09	1	2	2	1	3	2	4	1	2	1
10	2	2	4	4	3	3	4	2	3	3
11	2	1	2	3	2	2	1	1	1	1

Out of 110 responses to all questions in the Practitioner Survey only seven were negatively answered as "Disagree" and 13 were "Uncertain" (refer to Table 1). Thus the total number of positive responses were 90 out of 110.

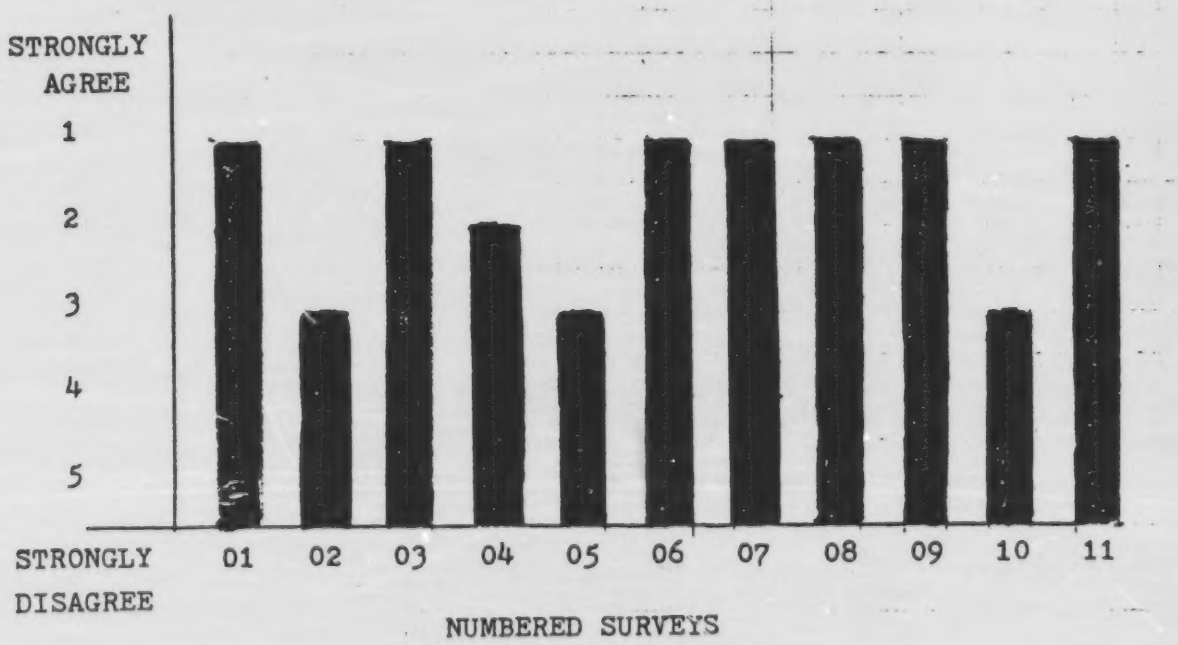
Question #10 stated: "Using this guide helped make my work with pregnant teenagers easier." This author

had designated Question #10 as added reinforcement for Objective Three. As stated, it expresses the fact that the guide helped the practitioner disseminate the information easily.

Out of 11 surveys, seven positively answered the statement with "Strongly Agree" or "Agree." There were three "Uncertains" and no negative responses (refer to Figure 3.0).

FIGURE 3.0

QUESTION 10- PRACTITIONER SURVEY



Objective Four specifically responded to the effect and use of materials in the guide aimed at academic low-achievers.

Question Five of the Practitioner's Survey stated: "The section on techniques for slow readers was useful."

Of the eleven surveys given, nine responded positively by answering "Strongly Agree" or "Agree." There were two "Uncertain" (refer to Table 1).

The response to Objective Five was mirrored in the discussion of Objective One. Both objectives dealt with the validity of the material used in the guide. Objective Five required a numerical response to illustrate its results.

The responses to Question Nine can be seen in Figure 4.0. Ten surveys out of eleven believed that the guide contained material useful in working with pregnant teenagers. All ten responses were "Strongly Agree" or "Agree." There was only one "Uncertain" response.

In order to see the extent and implications such a resource guide could have within the county and beyond, eleven supervisors and directors were included in the Expert-Panel Survey. Question Five of that survey addressed Objective Six.

Question Five stated: "I would recommend the use of this guide as a resource for working with pregnant teenagers."

FIGURE 4.0

QUESTION NINE- PRACTITIONER SURVEY

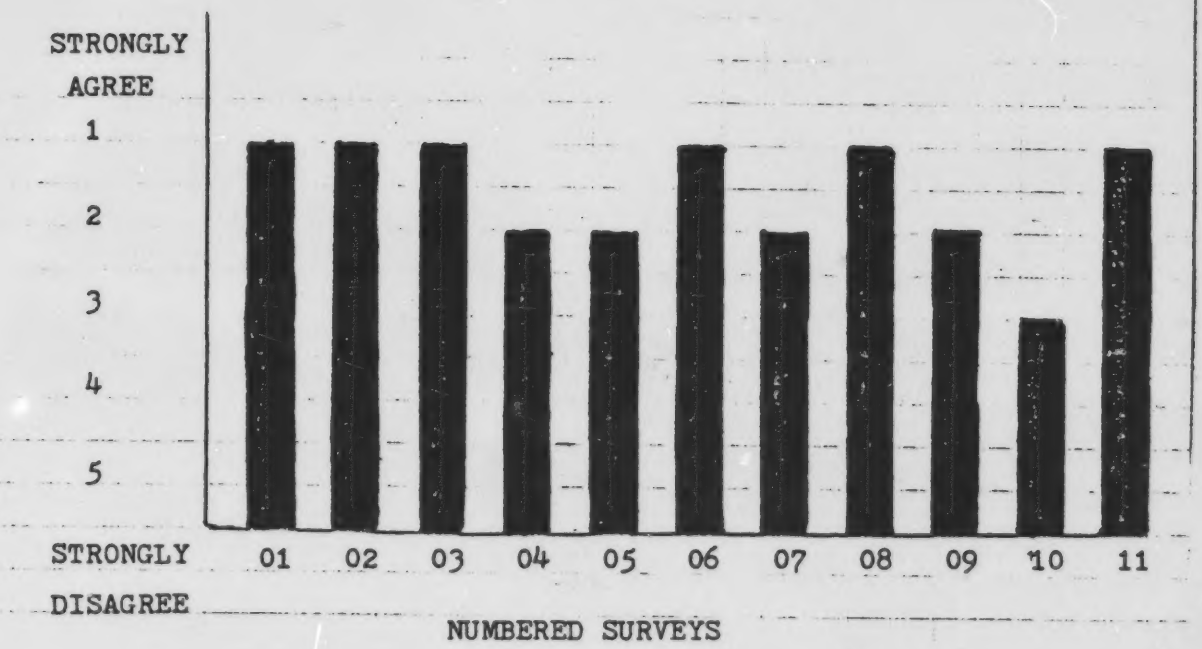
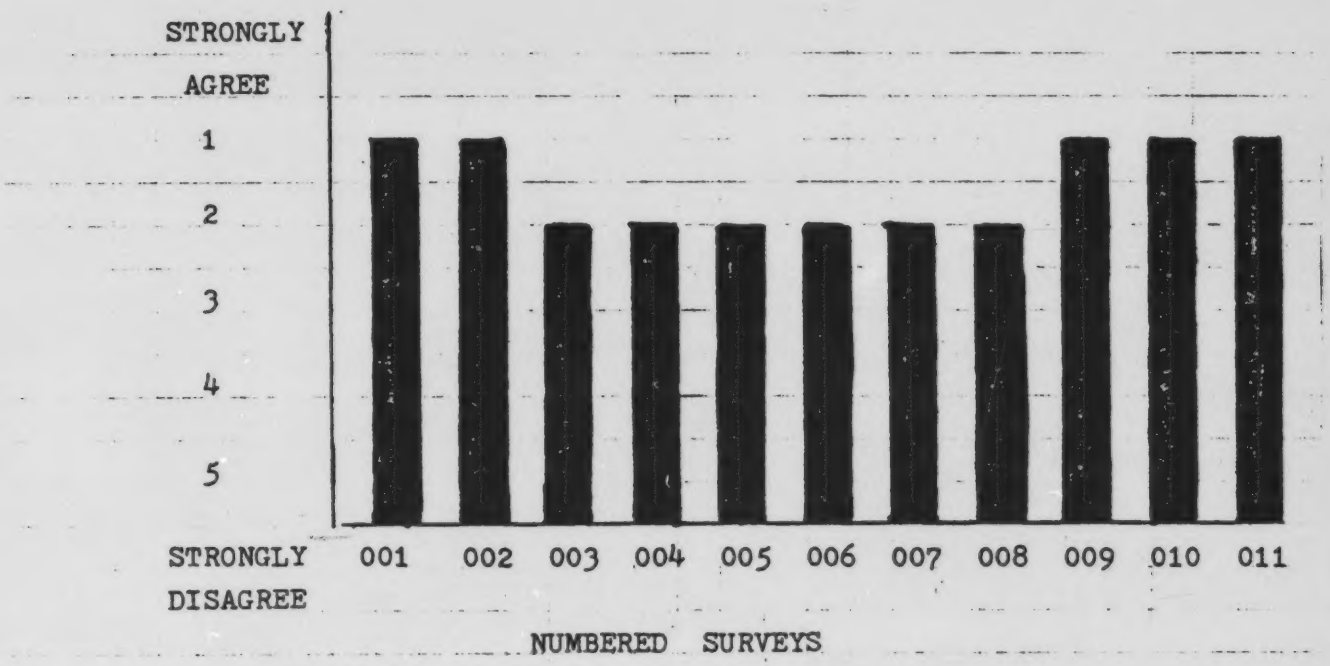


FIGURE 5.0

QUESTION FIVE- EXPERT- PANEL SURVEY



As shown on the graph in Figure 5.0, 11 out of 11 surveys chose either "Strongly Agree" or "Agree." There were no negative responses.

To further illustrate and in ways show a correlation between the practitioner's responses and those of the supervisors, one can cross-reference certain questions (refer to Table 2).

TABLE TWO

EXPERT-PANEL SURVEY

Strongly Agree	1
Agree	2
Uncertain	3
Disagree	4
Strongly Disagree	5

Surveys	Numbered Questions				
	Q1	Q2	Q3	Q4	Q5
001	1	1	2	2	1
002	1	1	2	3	1
003	2	2	1	3	2
004	2	2	2	2	2
005	1	2	1	2	2
006	1	2	1	3	2
007	2	2	2	3	2
008	1	1	1	1	2
009	1	1	1	1	1
010	1	1	1	1	1
011	1	2	1	1	1

Questions one, two and three of the Expert-Panel Survey were all answered positively. There were no "Uncertains" or negative responses. These questions were in response to Objective Two and the reaction was similar in the Practitioner's Survey.

Conclusions

It was predicted that the responses to each of the objectives stated would be 75% positive. (Objective One was fully realized with the development and completion of the guide itself.)

The results of Objective Two were determined by three questions on the Practitioner's Survey. All responses were positive equaling 100%. Thus, the results were well above the predicted percentage. The same held true for Objective Three. Ninety out of 110 responses were positive. Thus the 89% result far exceeded the 75% prediction.

Approximately 85% of the responses for Objective Four were positive. There was some comment with reference to the reason behind the uncertain responses for this particular objective. The subjects who marked "Uncertain" did so state to this author that they did not have an opportunity to utilize the sample lessons.

Ten out of 11 surveys responded positively in determining the results for Objective Five. Therefore, the 75% prediction resulted in over a 90% attainment.

It was also determined that the goal of Objective Six would be met with a 75% result. The total results, in actuality, measured 100%.

One can therefore conclude that all objectives were

met and in all cases, exceeded expectation.

There are a number of implications that can be drawn from these results.

First, the obvious one is that the guide did serve its purpose and provided easy and quick access to material needed for the education of the pregnant teenager.

The verbal responses by all those in the study were very enthusiastic. Most gave written suggestions for improvement and looked forward to seeing the revised edition. Apart from the usual typographical corrections and some rewording of structure, this author determined that the guide would have to be revised continually. This would be done in order to update and add new resource material as well as to correct changes in policy, philosophy or new medical directions in the field. This could be done by cross-referencing this guide with medical personnel, such as the nurse-practitioner or physician. It was noted that after the development of the guide, new immunization schedules were initiated, thus making obsolete the ones previously mentioned in the guide. The same situation was reflected with the use of sponge baths. This author was informed by one of the nurse-practitioners that they were no longer required and that a regular bath could be given to the newborn infant.

Written notations on surveys, as well as conversations

with subjects, revealed that the experience of the practitioner was related to the intensity of use given to the guide. Those with many years experience tended to utilize the guide with less reliance as a prime source. Those who were new to the field expressed the fact that the guide saved time looking up information in different sources. Its value appeared to be, in effect, that of a "cookbook" (Diane Scalese--Broward County Schools). This convenience was reflected in another statement. "I have so many different books, pamphlets, etc., I can't drag everything to each of the various clinics" (Karen Beam--Counselor in BCPHU Maternity). Thus, the guide provided a physical solution to the problem of transporting many materials from one site to another.

A second implication was reflected in the simplicity of the language. This author purposefully wrote the information in short, simple sentences. The rationale for this was that the level of experience, knowledge and education could vary greatly with each practitioner. It was also decided by this author that since there was no corresponding guide for the pregnant teenager, the wording of the information could easily be transferred to the adolescent verbadim.

Because of the simple language, a recommendation that it be used for Latin and Creole teens seemed on target.

The Broward County community has had a continual increase in Latin as well as Haitian population.

Nancy Almcroth, director of a Haitian prenatal program from Broward general Hospital and also a subject in this study had stated, "The three community interventionists who will be visiting the mothers have been hired and are training for the jobs. They are Haitians themselves" (Ft. Lauderdale News, Jan. 8, 1985). Ultimately, it is inevitable that at some point, lay people will be used in the education process. The simpler the language is kept, the easier it is to transfer information through such people.

Other positive responses indicated preferences for the parenting skills section, emphasis on allaying the fears of the teenager and emphasis on fetal development. "...appreciate emphasis on early fetal development since so many school programs downplay this; and students think they are not really pregnant with a real baby, rather just a blob of material--this certainly predisposes to irresponsible behavior and/or abortion" (Ilene Anderson, nurse practitioner, H.R.S.).

One can understand the need for the pregnant teenager to fully understand the process that is occurring to her body and the baby's. This understanding and information may provide the measure needed to produce a healthy baby

and a mother with self-esteem. "The number of negative conditions associated with teenage pregnancies besides infant and material mortality is well documented..." Stickle and Ma, 1967, Preventing Tomorrow's Handicapped Child Today, p. 4).

Questions of abortion or adoption are not discussed in the guide. This author felt that attaching general moral judgment to individual circumstances was not appropriate. Options such as these should be discussed privately with a counselor.

Suggestions from the population in the study were very helpful. Some wished to see a chapter on day care centers, the cost of hospital care, a chapter on how to avoid future pregnancies, and an extension of the chapter on the delivery process.

Cora Braynon, H.R.S. counselor and director of a program for pregnant teenagers, had indicated that many of the first-time pregnant girls have a lot of unrealistic expectations--e.g., "The baby's father will love them." She had also indicated that many of these girls have "great fears about the delivery process."

Implications indicate that more emphasis should be placed on the fears and emotional development of the pregnant teenager. There is a continued need for emotional and psychological support. Developing such a support system

is vital to any program involved with the pregnant teenager.

In conclusion, the adaption of this guide for use in departments other than the high school setting would be difficult to assess without first studying the individual department fully. Question 4 of the Expert-Panel Survey asked: "I can see the need for such a guide for my department."

Out of 11 surveys, seven indicated a positive response. The remaining four were "Uncertain" (refer to Table 2).

The departments covered in the practicum study included H.R.S. maternity, H.R.S. visiting teachers, Broward General Hospital Haitian Outreach Program, Henderson Clinic-HAPP Program, Health Education of the Broward County Schools, Exceptional Education Department of the Broward County Schools, Patient Education at Holy Cross Hospital, Adult Vocational Ed. of Broward County Schools, and supervisor of school nurses.

The majority of responses were positive. This author could easily see such a resource guide for most, if not all, the departments discussed.

In summarizing this analysis, one can conclude that the practicum study was successful. All objectives were met.

"The United States has one of the highest teenage birthrates in the world. Nearly 15% of all babies are born to teenagers--562,000 of them in 1980" ("Babies Having

Babies," Life Magazine, December, 1983).

With such statistics and an ever-climbing birthrate among teenagers--the need to educate is a problem of high priority. This resource guide was meant to ease that burden by its usage with teenagers remaining in the regular school setting and not cloistered at a center for pregnant teenagers such as Cyesis.

The guide provided all 22 subjects of the study with a compilation of information necessary to educate said teenager. The material was simply written, easily understood and easily accessible, as well as convenient.

Because of its structure, it could be used for non-English speaking students and adaptable for audiences other than teenagers. The possibilities of use with lay-practitioners such as teacher aides or volunteers is encouraging.

By providing as many people as possible access to such resource material, the job of educating the ever-increasing swell of pregnant teenagers does not appear surmountable.

Recommendations

The benefit of such a resource guide to the greater public is obvious. The problem of teenage pregnancies is a national one. Therefore, the need to educate should be a national priority. It is this author's belief that

information such as that which is in the resource guide, be made available to all guidance counselors, health teachers and regular teachers. It is important that people who are in contact with the teenager on a frequent and "regular" basis be privy to such information in order to provide it to the teenager in an informal manner if necessary.

This information could also be incorporated as a "required" course "before the fact" to ALL teenagers--male and female through their health classes. It is also recommended that these health classes be separated into male and female classes in order to allow for more freedom of expression without embarrassment.

Apart from hiring more people to deal specifically with the pregnant teenager in the school system, the next best thing is to make information available to those already in contact with the teenager--including lay-volunteers, such as parents and teacher-aides.

A volunteer program in the public schools could be set up to deal with just such a situation--incorporating the guide as a focal point. This would be one way of furthering the solution.

Other recommendations for the guide, outside the school setting, is its use as a resource for students in nursing programs or offered to newly employed counselors and nurses at the Health Department.

Dissemination

Most of the individuals and departments, within and without the Broward County School System, indicated a desire to have a "revised" resource guide made available to them at the completion of this practicum study.

The need is there. It is this author's contention that a revised form of this guide can be disseminated to all supervisors and directors of said departments.

This author intends to present to the curriculum supervisor in Health and Guidance recommendations previously suggested in hope that a volunteer program using the guide can be incorporated in the Broward County school setting.

This resource guide for the practitioner's use is already ear-marked to be included in the bibliographic references of the Haitian-Prenatal Program at Broward General Hospital which is under a grant from the Ford Foundation.

It is possible that this author could receive a grant to further a program using the guide in a middle school or high school setting. The guide could be disseminated to various nonprofit agencies such as Scout youth organizations, Salvation Army, Bnai Brith, March of Dimes, etc., in order to enrich programs already in progress or provide for a need not yet fulfilled.

BIBLIOGRAPHY

A guide for expectant parents, prepared by the EDN Corporation, Jenkentown, Pa.

A healthy start for you and your baby (1981). Mead Johnson Nutritional Division, Indiana, Ill.

Alley, G. and Deshler, D. (1979). Teaching the learning disabled adolescent: strategies and methods. University of Kansas, Love Publishing Co., Denver.

Almeroth, N., Coordinator of Haitian Prenatal Program of Broward General Hospital.

Anastasiow, N. (ed.), (1977). Preventing tomorrow's handicapped children today. Bloomington, Indiana: Institute for Child Study.

Anastasiow, N. and Everett and O'Shaughnessy (Oct., 1978). "Improving teenage attitudes toward children, child handicaps and hospital settings," American Journal of Ortho-psychiatry.

Anastasiow, N. (Feb.,1983). "Adolescent pregnancy and special education." Council for Exceptional Children.

Anderson, I., Nurse-practitioner, Broward County Multi-purpose Centers for H.R.S.

Baby care basics (1980). New Jersey: Johnson and Johnson Baby Products Co.

Barr, L. and Monserrat, C. (1979). A new beginning: a guide for use with teenage pregnancy. Albuquerque, New Mexico: New Futures, Inc.

Beam, K., H.R.S. counselor, BCPHU Maternity.

Be good to your baby before it is born. National Foundation March of Dimes, New York.

Bell, C. A.; Casto, G.; Daniels, D. (March/April 1983). "Ameliorating the impact of teenage pregnancy on parent and child." Child Welfare, Vol. LXII, N.2.

Birch, H. G. and Gussow, J. D. (1970). Disadvantaged children: health, nutrition and school failure, New YorK: Harcourt, Brace and World.

Boegehold, B. and Hooks, W. Junk food blues, Bank Street College of Education, prepared for the March of Dimes.

Braynon, C., Director of RAP Program for Pregnant Teenagers, H.R.S. Counselor.

Broman, S. H.; Nichols, P. L. and Kennedy, W. A. (1975). Preschool IQ, New Jersey: Erlbaum Associates.

Cappleman, M. (1982). "Effectiveness of a home-based early intervention program with infants of adolescent mothers," Child Psychology and Human Development, Vol. 13.

Catalog of public health education materials, March of Dimes Birth Defects Foundation, White Plains, New York.

Childbirth Education Association of Broward County, Tamarac, Fla.

Coles, R. (1971). Children of crisis: Migrants, sharecroppers, mountaineers, Vol. II, Boston: Little, Brown and Co.

"Dear mother," pamphlet. Pampers, Proctor and Gamble, Ohio.

Diepold, J. H., Jr. (June, 1976). Adolescent sexual behavior: a review of taboo (1945-1976). Paper presented at Indiana University, Bloomington, Indiana.

Dinkmeyer, D. Systematic training for effective parenting: parent's handbook, American Guidance Service, Inc., Circle Pines, Minn.

Eskin, B. A. "When do nocturnal emissions begin in adolescence? Does that date coincide with or resemble first menstruation in girls?" Medical Tribune, Feb., 1977.

"Every child and family matters," program developed as part of the Salvation Army's Education for Parenthood Program, New York.

FEED-Facilitative environments encouraging development curriculum guide, developed by Institute for Child Study, Indiana University.

Fisher, M. (Dec., 1982). "Cyesis," Miami Herald.

Gordon, M. "Learning for living," program report as part of the Salvation Army's Education for Parenthood Program, New York.

Gordon, T. (1970). PET-Parent effectiveness training, New York: Peter H. Wyden.

Harry, Graice (Dec. 18, 1983). "Teenage parents: they played the odds and lost," Miami Herald.

Kotulak, R. (Oct. 2, 1981). "Sex in America: the state of the union," Miami Herald. Copyrighted 1981, Chicago Tribune.

LaLeche League (1971). The womanly art of breastfeeding, LaLeche International, Franklin Park, Ill.

Lentz, M. (April 14, 1984). Article in Miami Herald.

Lindsay, J. (1981). Teen parenting: the challenge of babies and toddlers, Student Study Guide, California: Morning Glory Press.

Marbella, J. "Program to help Haitian mothers care for children," Ft. Lauderdale News, January 8, 1985.

Merrick, B. "Tender loving care," program developed as part of the Salvation Army's Education for Parenthood Program, New York.

Mirow (December 5, 1982). "Cyesis Article," Miami Herald.

Nichols, B. (March, 1984). Article in USA Today.

Salk, L. (1973). What every child would like his parent to know. New York: Warner Paperbacks, Warner Books, Inc.

Salvia, J. and Ysseldyke, J. (1978). Assessment in special and remedial education, Boston: Houghton Mifflin Co.

Scalese, D. Director of Health Education of Broward County Schools.

Segal, M. (1983). Birth to one year, New York: Mailman Family Press.

"Sexes" Article in Time Magazine, November, 1981.

Smith, C. (1982). "A needs-based curriculum for teenage mothers," Education, Vol. 102.

Sofferin, P. and Edler, L. Lifestyles: education and counseling program, Child Development Service, Lakeview Center, Inc., Pensacola, Fla.

Spock, B. (1974). Baby and child care. New York: Simon and Schuster, Inc.

"Spring Educational Review," (April 14, 1985). New York Times.

Stickle, G. and Ma, P. (June, 1975). "Pregnancy in adolescents: scope of the problem," Contemporary OB/GYN, New Jersey: McGraw Hill, Inc.

Stone, N. W. (May 13, 1975). "A plea for early intervention," Mental Retardation.

Sullivan, M. (1979). "Soap opera in the classroom," Educational Leadership.

Sung, K. and Rothrock, D. (July/Aug., 1980). "An alternate school for pregnant teenagers and teenage mothers," Child Welfare, Vol. LIX.

Wagemann, J. Director of HAPP Program for Pregnant Teenagers, Henderson Clinic, Fort Lauderdale, Fla.

Willis, A. and Ricciuti, H. (1980). A good beginning for babies: guidelines for group care, Washington, D.C., National Association for the Education of Young Children.

Wrenn, M. (December, 1983). "Babies having babies." Life Magazine.

Zelman, D. and Tyser, K. (1979). EASE: essential adult education for the mentally retarded. California: James Stanfield Film Associates.

APPENDIX A

PRACTITIONER SURVEY

PLEASE ANSWER BY CIRCLING HOW STRONGLY YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS. THERE ARE NO RIGHT OR WRONG ANSWERS.

	STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE
1. The material in the guide was easy to read and understand.	SD	D	U	A	SA
2. The introduction gave a clear understanding of the rationale of the guide.	SD	D	U	A	SA
3. There was a large variety of student handouts.	SD	D	U	A	SA
4. I used many of the student handouts.	SD	D	U	A	SA
5. The section on techniques for slow readers was useful.	SD	D	U	A	SA
6. The instructions on techniques for slow readers were clear and easy to follow.	SD	D	U	A	SA
7. I used many of the student activities.	SD	D	U	A	SA

PRACTITIONER SURVEY

8. The color-coded pages helped me find the information I needed quickly.	SD	D	U	A	SA
9. The guide covered the information I needed in order to work with the students.	SD	D	U	A	SA
10. Using this guide helped make my work with pregnant teenagers easier.	SD	D	U	A	SA

What information could be added to the guide to make it more complete?

What did you especially like about the guide?

What suggestions do you have, if any, to improve the guide?

APPENDIX B

EXPERT PANEL SURVEY

PLEASE ANSWER BY CIRCLING HOW STRONGLY YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS. THERE ARE NO RIGHT OR WRONG ANSWERS.

	STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
1. The material in the guide was easy to read and understand.	SA	A	U	D	SD
2. The introduction gave a clear understanding of the rationale of the guide.	SA	A	U	D	SD
3. The color-coded pages helped me find the information I needed quickly.	SA	A	U	D	SD
4. I can see the need for such a guide for my department.	SA	A	U	D	SD
5. I would recommend the use of this guide as a resource for working with pregnant teenagers.	SA	A	U	D	SD

USE THE BACK TO ANSWER THE FOLLOWING QUESTIONS:

A. What suggestions do you have, if any, to improve the guide?

B. What did you especially like about the guide?

C. What would be you suggestions for expanding its use?

APPENDIX C

RESOURCE GUIDE FOR PREGNANT TEENAGERS

A FACILITATOR"S GUIDE FOR PREGNANT TEENAGERS

BY RISA SLOANE
NOVA UNIVERSITY
FORT LAUDERDALE, FLA.

TABLE OF CONTENTS

TITLE	PAGE
Rationale and Use of Guide----------	1
Part One (Prenatal care and Childbirth)	
Introduction----------	4
Objectives ----------	5
Objective One----------	6
Objective Two----------	11
Objective Three----------	14
Objective four----------	17
Objective Five----------	20
Part Two (Newborn)	
Introduction----------	29
Objectives----------	30
Objective Six----------	31
Objective Seven----------	33
Objective Eight----------	37
Objective Nine ----------	39
Objective Ten ----------	42
Objective Eleven----------	45
Part Three (Child Development and Parenting)	
Introduction----------	49
Objectives----------	50
Objective Twelve----------	51
Objective Thirteen ----------	54
Objective Fourteen----------	59
Student Activities----------	66
Sample Lessons----------	72
Resource Materials----------	75
Student Handouts----------	A

RATIONALE AND USE OF GUIDE

Teenagers are child/adults. They are in need of nurturing, guidance, information about the changes they are going through and the need to develop a strong sense of self-worth.

The needs of the teenager can be demanding. When added to the complication of pregnancy, the results can be devastating. The lack of self-worth is why some teenagers become pregnant in the first place. Some are looking for a little'being' to look up to them and love them.

But the very process of having to care for an infant and child can produce the exact opposite effect; leaving the teenager with feelings of helplessness, ineffectiveness and self- doubt.

The primary goal of this curriculum guide is to help the practitioner provide some guidance and information of pre-natal care, child growth and development and parenting. The primary objectives include:

To promote the development of concepts of adult responsibility for the teenager.

To increase awareness and need for proper health care for the pregnant teenager and baby

To increase the teenager's knowledge of the physical, psychosocial and emotional development of children

To increase skills needed to provide for the needs of the infant and young child

This can be provided in a structured manner although the setting may be informal. The guide can be used on a strictly one to one basis or for use with small groups.

Each area is self-contained and can be used in any order. This depends entirely on the judgment of the practitioner as to the needs of the particular student and how advanced is the state of pregnancy.

The program guide provides objectives, information, resource materials, activities, student handouts and sample lessons. It does NOT provide all the information necessary to present a lesson. The list of resource materials and bibliographic references are provided for the practitioner as a means of obtaining that information.

The list of vocabulary words and suggested activities are specifically kept at a minumum for a number of reasons:

Learning long lists of words can be a'turn-off' to teenagers who look to these sessions as a means to express their personal thoughts and problems related to the pregnancy. The pregnancy itself is a strong motiviation for learning.Another reason for limiting the amount involved in the lessons is a means of considering the low-achiever. Some students have done poorly in school. They may be poor readers. They may have already lost time in school for pregnancy related problems. Their emotional state is in a flux. Therefore they may be distracted and unable to concentrate on academic endeavors over a long time period. Providing a variety of activities of short duration will keep their attention.

Limiting the number of activites and vocabulary also takes into consideration the time allotment provided. A practitioner may see a student only once a day or once a week in a 50 minute

period. The teenager may be in the first or in the last trimester of pregnancy. This would seriously limit the time in which to provide all the information.

It is strongly suggested that the practitioner incorporate as many concrete experiences as possible. Field trips to hospitals and care centers provide the hands-on experience as well as direct contact with infants and young children.

It is understood that the social workers and counselors using this guide have had experience in counseling or dealing with people in stressful situations and realize the importance of maintaining open communication with the adolescent. It is critical to be aware and sensitive to the fact that the practitioner's own values may be different from those of the adolescent. Therefore a non-judgmental approach is of extreme importance in order to maintain that relationship.

The pregnant teenager needs to feel accepted so that she can develop a better self-image and can 'like' herself again. This is achieved by contact with people who are supportive, compassionate and patient.

INTRODUCTION

This section provides the objectives and activities related to health and attitudes with regard to the developing fetus and the well-being of the teenage mother.

Emphasis should be placed on the concept that TWO changes are occurring. The first is the growing and developing embryo. The other is the change taking place with the mother's own body. Both require specific care.

Knowledge of what is happening to her body, the birth process, and the options availible are extremely important. It is a means of dispelling the fear and anxiety surrounding childbirth.

PART ONE

OBJECTIVES

1. The student will learn the stages of fetal development and signs of pregnancy during the various stages.

2. The student will learn what health precautions she should take while pregnant. Such knowledge should motivate her to seek medical care as early as possible.

3. The student will learn to identify those influences such as smoking, drugs and alcohol which could be a danger to her unborn child.

4. The student will understand the need for a basic foundation in good nutrition and well-balanced meals.

5. The student will eliminate much anxiety and ignorance as she learns about the birth process-- the signs of labor, the control of pain and the various options of delivery.

PRACTITIONER INFORMATION

OBJECTIVE ONE (the baby)

I.THE FIRST TRIMESTER

a. The beginning of life occurs when the sperm cell (from the male) joins with the female's egg. This is called FERTILIZATION.

b. The sperm will determine if the baby will be a girl or a boy - NOT the mother.

c. The cells divide and grow. Part of the cells become the baby and some of them become the PLACENTA and UMBILICAL CORD.

d. At two weeks there are thousands of cells and the brain is beginning to form. By six weeks the EMBRYO has bone formation a heartbeat, and the beginning of ears and eyes.

e.At twelve weeks the embryo is called a FETUS. At this point all of the inside organs are complete and it is almost 3 inches long. The arms,legs, fingers and toes are well-formed.

II. THE SECOND TRIMESTER

a. The sex of the baby can be seen. The baby develops hair, eyebrows and eyelashes.

b. The skin is wrinkled and the eyes can open. The baby will sleep and wake. It responds to the mother's movement.

c. The baby can move, turn and swim inside the water of the womb. This provides exercise. By six months it will weigh about two pounds.

III. THE THIRD TRIMESTER

a. At this time the baby is mainly gaining weight and length. At seven months it is about sixteen inches long and approximately 3 to 4 pounds.

b. The baby has a good chance of survival if it is born anytime after the seventh month. It isbuilding up a fat layer and has maintained a white creamy coating on its skin for months in order to protect it from the moisture.

c. It can hear sounds and may even suck its thumb. It can hiccup and cry. All babies' eyes are usually slate in color when first born. The color becomes more definite much later.

PRACTITIONER INFORMATION

OBJECTIVE ONE (the mother)

I. THE FIRST TRIMESTER

a. If you are pregnant some early signs may include a missed menstrual period. (Though some women may even have a small flow at the regular time during the first few months)

b. The reason why your period stops is because the blood and tissue will be used to provide a 'nest' for the growing baby.

c. Some women may experience none, some, or all the early signs of pregnancy. Each person is different!

1. tiredness or sleepier than usual

2. breasts may grow larger and feel tender. The nipples may appear a little bigger and darker.

3. some women have to urinate alot

4. others may have an upset stomach and feel nauseous. This is called'morning sickness' but it can occur at anytime of the day.

d. This is a time when the body is making a change to prepare for the growth of the baby. The teenage mother should know that it is ' normal' to get upset easily at this time.

e. The adolescent may feel 'blue' or depressed and cry easily.

f. The importance of getting in contact with a doctor or clinic is vital. The earlier the teenager does, thebetter her chances for optimum care and protection for herself and the baby. Most of the signs previously mentioned subside by the third month but everything should be discussed with a doctor.

II. THE SECOND TRIMESTER

a. Breasts are larger but will not grow as much after this.

b. Some thin yellow liquid (It may crust on the outside of the nipple) may come out. It is called COLOSTRUM and implies that the breasts are getting ready to produce milk.

c. At this time your body adjusts better to the pregnancy. The adolescent will have more energy, feel better and be in a better mood.

d. The teenager should know that between the forth and fifth month she will begin to feel some movements or fluttering in the abdomen.

e. Some women show skin changes as well. A line may extend down the middle of the tummy. This will usually fade after the birth of the baby. Also some stretch marks may appear as the skin stretches to expand with the fullness of the abdomen and breast.

f. At this point the UTERUS (womb that holds the baby) moves upward into the abdomen because the baby is getting bigger. It is at this time that the waist gets bigger, the stomach sticks out and you look pregnant.

III. THE THIRD TRIMESTER

a. Some symptoms may reappear- such as tiredness due to the increase in weight.

b. Other symptoms may occur. These are due to the fact that the growing baby is making demands on your body. They may include heartburn, constipation, fainting or dizziness, hemorrhoids,

varicose veins and some swelling of your hands and feet. Most of these conditions can be relieved by seeing you doctor.

c. You may feel warmer than those around you and it may also be hard for you to sleep comfortably in some positions.

d. It is important to impress upon the adolescent that these conditions are TEMPORARY and go away after the birth of the baby.

e. The muscles on the uterus are becoming stronger and you may experience the feeling of them tightening. These painless contractions help prepare the muscles for labor.

f. At this time the movements of the baby are stronger. You may even 'see' the baby kick and form a bulge on the abdomen. It is good to know there is activity because it shows that the baby is alive and strong.

PRACTITIONER INFORMATION

OBJECTIVE TWO

A. Emphasize that even though the baby is very small, the most important parts are developing in the first three months of pregnancy. They are the brain, the spine and the heart. The sooner the adolescent understands the importance of seeing a trained specialist such as a mid-wife nurse or doctor the better it will be for her and her unborn child.

B. The following covers most procedures that the adolscent should expect to find on her first visit to the doctor.

1. First the doctor will ask at what age you started menstrating.

2. Then the doctor will ask for the date you had your last period.

3. The doctor may ask you if you have taken any drugs or how much you drink alcohol and smoke. Stress the fact that the doctor is not trying to judge the teenager. These are things that can harm the baby and he is concerned about both of them.

4. The doctor will ask about your health and the health of your family.

5. You will be weighed and blood pressure will be taken. A normal weight gain for pregnant teenagers is about 24 to 30 pounds.

6. A blood test will check the following things:

a. V.D. test to see if you have syphillis

b. hemoglobin- this is to check if you have enough red blood cells (for oxygen and iron)

c. Blood type- are you A, B, AB, or O ?

d. RH Factor- to see if you are RH- or RH+

e. Rubella Titer- this is to check if you had the German measles or are immune to it.

7. The doctor will give you a complete physical exam. He will check your heart and lungs as well as your throat, ears and eyes.

8. The doctor will check your breasts and give you a PELVIC EXAM.

a. The doctor uses a SPECULUM (a metal or plastic instrument) to look into the vagina. He will scrape some cells for a PAP SMEAR (a test for cancer)

b. He will look for signs of pregnancy and infection.

c. He may insert two fingers into the vagina to feel the position of the UTERUS.

d. Reinforce the fact that although the PELVIC EXAM may make the teenager feel embarrassed, it is an important part of the care and takes just a few short minutes.

C. Emphasize the importance of rest and exercise - eight to ten hours of sleep a night is appropriate.

D. Remind the young mother-to-be to take a warm shower every day. Discuss the sponge bath as an alternate method of bathing if the environment is not suited to the former. It is important NOT to use bubble baths because they have been known to produce infection and irritation to the vaginal and urinary tract.

E. Care of the breasts: It is important to stress the need to wear a bra to prevent sagging. If the adolescent intends to nurse, there are some nipple massages that will toughen them and prepare them for nursing.

F. Douching is NOT recommended at any time. It can increase the risk of vaginal infection.

G. Sexual relations during pregnancy is not considered dangerous. But the teenager should be aware that if she DOES experience pain or bleeding, she should STOP.

Blowing into the vagina can be extremely dangerous because it can cause an air EMBOLISM(air bubble) and result in harm or death to both the mother and fetus.

Generally, doctors advise couples to stop having intercourse just 3 to 4 weeks before the delivery date because there may be some risk of bringing on an early labor
BUT CHECK WITH YOUR DOCTOR CONCERNING THOSE FACTS JUST MENTIONED.

H. Exercise is good during pregnancy. It helps the circulation and the digestion. Remind the adolescent not to take up something totally NEW and to pace herself so as not to get overtired. The local hospitals usually have access to information in the form of prenatal classes or booklets. (do not sit with crossed legs.)

I. THE WARNING SIGNS AND NEED FOR EARLY TREATMENT

1. swelling in face, hands and/or feet- may indicate TOXEMIA
2. blurred vision- indications of high blood pressure or toxemia
3. Bleeding from the vagina- may indicate sign of misscarrage or a problem with placenta attachment.
4. severe or constant headaches or fainting
5. severe or constant vomiting
6. fever and chills
7. burning and pain upon urination- may indicate kidneyinfection
8. sharp constant pain in the abdomen- may be advanced toxemia
9. a sudden gush or steady drip of fluid from the vagina - may indicate premature breaking of the bag of water.

PRACTITIONER INFORMATION

OBJECTIVE THREE

* NOTE: When discussing birth defects due to maternal environment (drugs, alcohol, etc.) it is vital to be aware of the fact that some of the young mothers may have ALREADY been involved with such substances and are frightened of its consequences. That mother will need to be reassured that her baby will be alright. But the practitioner must emphasize the importance of being responsible and the dangers such activity can produce. Therefore, in order to be sensitive to needs, this objective should be best approached on an individual basis.

A. What causes birth defects?

1. heredity- genes from the sperm or egg not only tell what color the hair of the baby is or whether it has big eyes or small ones, they may also carry a defect such as Sickle- Cell Anemia, Tay- Sachs Disease or Cystic Fibrosis.

2. environment- pollutants such as chemical wastes and pesticides. Radiation from medical or dental exams should be avoided. Do not stand near microwave ovens as well.

3. Maternal environment- what the mother does to her own body and its effect on the unborn baby.

B. Areas of Concern:

1. S.T.D. (Sexually Transmitted Diseases). It is important to see a doctor as soon as you suspect any symptoms of these diseases which can show up in or near the mouth, sex organs or anus. Such symptoms may include open sores, rashes, discharges or irritation. There may be fever or no symptoms may be evident. That is why it is important to be examined by the doctor as soon as you suspect you are pregnant. These diseases are passed on through sexual intercourse. Many of these diseases such as

Syphilis, Gonnorehea and Herpes, can cause heart disorders, mental retardation, blindness, miscarriages etc. Herpes Symplex II kills more newborn babies than Congenital Syphilis.

2. Infectious diseases- Some diseases are dangerous to the pregnant woman and her unborn baby. The teenager should be aware and avoid contact with sick pople. Some infections that hardly bother the mother can damage the baby.

a.- Rubella or German Measles can cause a baby to be born blind, deaf or retarded.

b.- Toxoplasmosis is an infection from cat feces which can cause birth defects- Have someone else empty its litter box if you have a cat.

c.- Toxoplasmosis can also be found in raw or undercooked meat. Therefore make sure all meat is cooked thoroughly.

3. Alcohol (FAS - Fetal Alcohol Syndrome) This substance can damage the baby's looks, growth and brain. It can also destroy your own brain cells. Please avoid excessive or steady alcohol consumption.

4. Smoking- This is harmful at anytime in life, especially during pregnancy. Mothers who smoke risk having babies born too small or too soon (premature). This can damage the baby's health and cut down on the development of its brain cells.

5. X- Rays- It is vitally important to impress upon the teenager that she must be sure to tell any doctor or dentist who prescribes x-rays, that she is pregnant. None should be taken the first three months if possible. Later on, precautions to protect the abdoninal area (with a lead apron) during x-rays for a dental exam or extremities (arms, legs, etc.) should be observed.

6. Drugs- Impress the fact that when the mother takes ANY medicine the unborn child does also. (It goes through the placenta) Very little is known about the effects of most drugs or combinations of drugs (prescription or non-prescription). The pregnant teenager should not take pills or medicine (including over- the- counter) such as aspirin, cold medicines, antacids or laxitives unless prescribed by the doctor.

There is no question that " street drugs" such as Marijuana, L.S.D., Angel Dust, Cocaine, Heroin, etc. can harm the health of the user. Babies of Heroin addicts are often addicted at birth.

OBJECTIVE FOUR

* NOTE: The pregnant teenager is considered " at-risk" nutritionally. This is because of generally poor eating habits and large consumption of snack foods. There is also the possibility of bad effects from " fad dieting" caused by erroneous attitudes about body image and the need to be slim. The adolescent should realize that the teenager AND the unborn baby go through a natural acceleration of growth during these times in their lives. Therefore if the teenager is pregnant as well, she must make doubly certain that she is eating properly. This will insure her own health and the health of the baby.

THERE IS A DEFINITE CORRELATION BETWEEN MALNUTRITION AND MENTAL RETARDATION.

A. Weight Gain: The total weight gain over the nine month period should be between 24 to 30 pounds. Impress upon the adolescent that much of this is immediately lost with the birth of the baby.

average baby weight : 6 to 9 pounds
fluid, afterbirth, placenta: 12 to 14 pounds

B. The only food the baby gets is what you (the mother) eats every day. All foods that are good for you are also good for the baby.

C. Nausea: Before getting out of bed or when you feel squemish, eat a few dry crackers. It is NOT a good idea to starve yourself. Nausea is helped by keeping a little something on your stomach throughout the day. It may help to eat four or five small meals

a day rather than the usual three meals.

D. Water: Drink 6 to 8 glasses of water or other fluid each day. This will help flush or carry away waste products in the body and help the body get and use important nutrients.

E. Salt: This sometimes causes swelling of the hands, feet and face. It may affect high blood pressure and cause you to retain fluid. Check with your doctor. It may be best to avoid foods with too much salt such as chips, pretzels, cold cuts, pickles etc.

F. Helpful Hints: Avoid eating too much of anything. Don't make sudden changes in your diet. The more fresh and natural foods you eat the better. Your doctor may want you to take additional vitamins, minerals and iron. Take ONLY what he prescribes. VITAMINS DO NOT REPLACE A GOOD DIET.

G. The pregnant teen needs the following foods EVERY DAY:

MILK GROUP----------4 servings (5 if breastfeeding)

1 serving equals 1½ slices of cheese, 1 cup of yogart, or ½ cup of cottage cheese, 1 glass of milk

This group is needed for strong bones and teeth.

PROTEIN FOOD GROUP----------4 or more servings

1 serving is equal to 2 to 3 ounces of meat or 1 egg, or ¼ cup of peanut butter

This group helps build tissues and organs. It is important for delivery and recovery

---

FRUIT AND VEGETABLE GROUP--------- 4 or 5 servings

1 serving equals 1 piece of fruit or ½ cup cooked or canned vegetables or 1 cup raw vegetables

This group is needed for healthy teeth, blood vessels, gums, eyes, skin.

BREAD, CEREAL AND GRAIN GROUP----------5 to 6 servings

1 serving equals 3/4 cup dry cereal or ½ cup cooked cereal or 1 slice of bread or 1 large tortilla or ½ cup cooked noodles, rice or macaroni or 1 biscuit.

OBJECTIVE FIVE

* NOTE: This objective covers three areas of concern. The first deals with the birth process. This includes the stages of labor, the use of medications and the alternatives of delivery. The second provides the young mother with a list of things to do and bring in order to organize her preparation and understand hospital procedure. The third part discusses the types of births which may occur, post-partum results and the choice to breast-feed.

It is important at this time to minimize the concept of pain in order to lessen anxiety. The more that various terms can be described in a concrete manner (not so technical), the better. For example, the act of pulling your head through a turtleneck sweater is a concrete example of how the cervix dialates(opens) and effaces (thins out) to allow for the birth of the baby. Also emphasize that choices about delivery do not necessarily have to be made immediately. It can be a joint decision with the doctor.

A. Arriving at the Hospital:

1. Usually the time to go to the hospital is when your contractions are 5 minutes apart--or if your water breaks--or if there is heavy bright red bleeding. Call your doctor before going.

2. Packing for the hospital:

a. identification- It could be a health card from the clinic, insurance policy numbers, etc.

b. cosmetics- Toothbrush, toothpaste, brush, comb, talcum powder, shampoo, soap, deoderant,sanitary pads (there is a discharge for a while after you give birth)

c. clothes- robe, slippers, nightgown, bra, (nursing bra if necessary) panties. Make sure the clothes you bring to go

home in are loose fitting and comfprtable. Although you will lose some weight immediately, your body will not be able to fit into your regular size at that time.

d.If you plan to keep the baby, items for the baby to take home should include a T-shirt, diaper, blankets.

3. Admission to the hospital

a. Some hospitals ask you to go to the EMERGENCY ROOM. Others have you sign in at the front desk. Check that out.

b. You may be asked to ride in a WHEELCHAIR. This is to make sure there is no accident. So you don't fall.

c. You will have an EXAM just like the one on your first visit to the doctor to check if you are in true labor.

d. You will be asked to put on a hospital gown and the baby's heartbeat will also be checked.

e. A PREP will be given. The hair around the vaginal opening is shaved to keep the area clean and to keep hairs from getting into the stitches. Some hospitals also give ENEMAS. This is when some fluid or water will be put into the rectum through a tube or plastic bottle. This does NOT hurt. It will just make you need to go to the bathroom. This helps make more room for the baby to come out.

f. Labor room- the mother-to-be will stay in this place until the baby is ready to be born. It is here that ONE visitor is allowed to stay with you and help you feel more comfortable. (That person can help you with breathing exercises, relaxation, rub your back or give you some ice chips to suck on-Remember you should NOT eat or drink anything while you're in labor)

The doctor will have you attached to an I.V. This is a needle that is put into the back of your hand or arm. It provides sugar water to give your body energy and the fluids you need. The doctor can also use it to introduce medicine if you need that also.

g. Delivery room- You will be taken to this room when it is time for the baby to be born. Your legs are lifted up onto stirrups like those in the doctor's office. Everything around you will be 'sterile ' or clean. Sheets will cover you and the opening of the birth canal will be washed. There is a mirror above the table so you can see the baby being born if you wish or if you are awake at this time.

h. Recovery room- After the baby is born you may be taken back to the labor room or another room called the recovery room. It is here that your blood pressure and pulse will be taken and you will be watched over. The nurses will check the bleeding and massage the uterus to help cut down on the bleeding.

B. Alternatives of Delivery:

1. Prepared Childbirth- having a baby is work and you use many muscles not called upon before this time. Very few women go through labor and delivery without SOME discomfort. Learning about labor and learning ways and exercises to make it easier are helpful. If the teenager learns the methods that groups such as CEA and PACE (given at the end of the chapter under resources) teach,the young mother-to-be may wish to stay awake and take an active part in the labor. Even if the choice is to take medication to ease the pain or to be asleep, learning these methods are still very worthwhile. ANXIETY is removed with understanding.

2. Analgesia- is a drug that is given to remove some of the discomforts of labor. They may be in the form of pain killers or tranquilizers. These will help you relax but they cannot take away ALL the discomfort.

3. Anesthesia- This is a drug that takes away all the feeling in your body. (It makes you feel numb- like a shot at the dentist's office.

a. General Anesthesia- This is a gas that puts you to sleep. Gas can make you vomit. (That's why you're not suppose to eat anything while your in labor) The baby may also be a little sleepy when it is born because it goes into the baby's nervous system. Most doctors prefer to limit its use.

b. Regional Anesthesia- puts an area or part of your body to sleep while you remain awake. You feel no pain and may be able to help with the delivery.

1. Saddleblock or Spinal- This shot is given into your back right before the baby is born. There is no feeling from the waist down to the toes. Therefore you will need help 'pushing' the baby out. The doctor may lift the baby's head out by using metal instruments called FORCEPS.

2. Epidural or Caudal- This is given in the lower back during the hardest part of labor. A small tube can be left in place if more medicine is needed. You feel numb from the waist down to the thighs.

3. Nerve Blocks- A paracervical can be given at the cervix to ease the pain while it is opening up. Another block can be given just inside the opening of the birth canal when you are ready to deliver. It is called the pudendal and is usually given

for the EPISIOTOMY.

c. The decisions for the type of analgesia or anesthesia you may want can be discussed with the doctor. The type of delivery you have depends on many factors. These include how prepared you are for labor, your beliefs about childbirth, what is your reaction to pain, the health of the baby, your health, the length of you labor, etc.

C. Signs of Labor Beginning

1. Lightening- baby moves down lower (drops) into the pelvis.

2. Vaginal discharge (bloody show)- the mucus plug which consists of some mucus mixed with a little blood will dissolve. This may occur 24 hours before other signs begin.

3. Rupture of membrane- bag of water may break, sending out a gush or trickle of fluid.

a. call a doctor at this time
b. wear sanitary pads- (prior to due date it is a good idea to cover the bed with plastic or a towel incase this happens)

4. Contractions of the uterus- this is the hardening and tightening of the uterus. There may also be pressure on the pelvis or in the back. (watch for a PATTERN. TIME THEM.)

* The length of labor is different for every pregnancy. Most women have their babies eight to eighteen hours after labor begins.

D. Stages of Labor

1. The first stage takes the longest time. During this time the cervix thins out and opens to allow for the head of the baby to come through. (4 inches or 10 centimeters)

The contractions may become stronger and more uncomfortable. This is a time to relax and use some breathing techniques. You may want to have some medicine to help you relax. (contractions come every 2 to 5 minutes and last from 45 seconds to one minute). The end of the first stage is ca[illegible]d transition. Contractions are

longest and very strong. It will be difficult to relax. Fast - shallow breathing exercises are useful now. You may feel irritable and not want anyone to touch you.

2. The second stage of labor is when the baby moves down the canal and there is a great urge to push just before the baby is born.The doctor makes a small cut at the vaginal opening. This is called an EPISIOTOMY. It prevents the vaginal opening from tearing as the baby is born. (It is stitched up right after birth.)

3. The third stage of labor is called the delivery of the placenta. This 'nest' is no longer needed and now separates from the wall of the uterus and comes out.

After the baby is born the umbilical cord is cut and the baby is examined and weighed, measures, and bathed. Sometimes before or after this, the nurse may hand you the baby to hold and put to the breast if you are awake. This nursing helps to move the uterus back into place. You can do this even if you don't intend to breast feed.

E. Types of Births

1. Cesarian Section- sometimes the way a baby is born is not always planned. The baby may have some difficulties and cannot go through the birth canal. At this time the doctor makes an incision in the woman's abdomen and uterus and lifts the baby out. If you have one it is because the doctor feels it is the safest way for you and the baby.

2. Breech- the legs or behind of the baby comes out first and then followed by the body and head. Instruments are generally used. The mother is usually anesthesized.

3. Transverse- The baby lies crosswise in the uterus. If

the doctor cannot change the position, the mother is anesthesized and instruments may be used or a Cesarian section done.

4. LeBoyer Method- (Birth without Violence) Atmosphere is quiet and lights dimmed in the delivery room. Immediately after birth,while the cord is still intact, the baby is placed on mother's stomach and the baby's back is gently massaged. As the cord is cut, the baby is placed in a warm bath and allowed to respond naturally. This is an attempt to prevent childbirth from being a traumatic experience for the baby.

5. Lamaze Method- This is usually taught in the prepared childbirth classes. It is a directed method for 'prepared' childbirth and includes breathing exercises to control the discomfort.

F. Post- Partum Concerns:

Many younger women think that the body will immediately return to the pre-pregnant state. They are not prepared for the discomfort of episiotomies, bloody discharges or problems urinating or having a bowel movement. Reassurance that these conditions are TEMPORARY helps promote better feelings about their body.

1. After the birth of the baby, it will take approximately six months to a year for the body to get back into shape (internally and externally). Remember- it took nine months to get that way.

2. Exercise - Some of the prenatal exercises as well as those given by many hospitals for post-natal recuperation are helpful. Eating well-balanced meals also helps. Breast-feeding is one way to get your uterus back into shape. It also helps you to lose weight slowly because you are burning calories to produce the milk.

3.Breast-feeding

a. - This may be an option for you if it doesn't interfere with school or job. It is possible to do both if you use a supplemental bottle at the times you cannot be there.
** But do not start using the bottle the first four weeks. Your breasts have to establish their milk supply.

b.- There is nothing to prepare, wash or sterilize. It saves money also. It saves time because the baby does not have to wait to be fed. You do not 'run out' of food and have to rush home if you are out with the baby.

c.- Nursing stimulates the production of hormones which aid in the prevention of ' post-partum blues' and increases motherly feelings toward the baby.

d.- It provides 'antibodies' to fight against getting sick. Babies who breastfeed also do not get allergic to milk and suffer less intestinal upsets.

4. Being overly 'fatigued' or tired as well as being unable to cope with the new role of being a mother can cause some depression or 'baby blues'. Part of that is from a natural HORMONAL change. It is important that the adolescent mother be aware that TIME will diminish this condition.

5. Healing of Episiotomy - stitches dissolve in one to two weeks. Soaking in warm water eases the discomfort.

6. Menstrating-

a.- Non- nursing mothers usually have a period within 12 weeks

b.- Nursing mothers may not have a period until lactation ceases.

c.- Pregnancy is possible even if the mother may not have had a period.

7. Regular school work and activities may resume within 2 weeks.

8. Maternal feelings develop slowly- Stress the realistic expectations immediately following childbirth. Attachment to the baby grows with contact. BONDING is discussed in the next chapter.

9. Family Planning- Discuss types of birth control and the importance of preventing pregnancy too soon after the birth of a child- It is important for the psychological as well as physical health to both the young mother and the newborn.

* Chart of methods of birth control included in the student handouts

INTRODUCTION

This section concentrates on the importance of newborn care. It covers the physical needs of the infant such as " how to" diaper, bathe, health concerns, etc. It also covers questions pertaining to the sleeping, crying and eating habits of the infant so that by understanding them, the proper physical and psychological care is given.

A positive approach through understanding needs, minimizes anxiety on the part of the teenage parent and prevents the possibility of child abuse through ignorance. It is important to emphasize that the first two years of a baby's life are vital to its future development and any deprivation can cause permanent or long term disabilities.

PART TWO

OBJECTIVES

6. Discussion of Bonding will enable the student to understand the complexity of maternal feelings and develop a realistic approach to parent-child relationships.

7. The student will learn about the physical and social development of the infant in the first two months.

8.The student will understand the importance of answering the infant's cries as soon as possible.

9. The student will learn about the patterns of infant feeding and sleeping as well as the importance of <u>always</u> holding the baby when feeding.

10. The student will learn how to provide for the physical needs of the baby with regard to bathing technique and the list of equipment and clothing required.

11. The student will understand the importance of providing proper health care and safety measures.

PRACTITIONER INFORMATION

OBJECTIVE SIX

A. Maternal and paternal attachment to the newborn is referred to as bonding. It was thought at one time that bonding only took place in that period following birth, but further studies have indicated that this process repeats itself many times throughout our lives. Expressions of love and acceptance are manifested through activities such as feeding,kissing, holding, touching and establishing eye to eye contact.

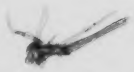
B Emphasize to the new mother that it is natural to feel like a stranger to the baby at first. Sometimes the baby may not look the way you expected it to look. Most babies do not look pretty or handsome. Their faces are wrinkled (due to being in fluid for nine months) and their heads and noses are misshappened. This will correct itself in time.

C. New parents need to spend time touching their baby and holding it close. Talking to your baby and holding it close , making sounds, singing to it will bring the parent closer in feeling to the child.

D. Some babies are more nervous than others. Their bodies may need some more time to physically develop in that area. They may appear more hyperactive and 'jumpy'. This baby may need more soothing, rocking and cuddling than another type of baby.

Emphasize that this type of baby may take longer to respond in a happy way to the new mother- even if she is doing all the right things. Tell her not to be impatient and take the poor response personally.

E. It is the responsibility of the parent to provide the baby with 'loving care', affection and love. A baby can literally die from lack of affection or cuddling. Emphasize the importance of holding the new infant as much as possible. (The baby can become angry or frightened by rough handling. The head and spine need support when lifting.)



PRACTITIONER INFORMATION

OBJECTIVE SEVEN

A. Physical Development:

The teenage mother should be aware that newborns have certain characteristics in common.

1. The head may appear too large for the body. It may also have an unusual shape. This is due to the fact that it was squeezed as the baby came through the birth canal. There is a soft spot on the top of the head called a FONTANEL. This is where the bones haven't grown together yet. It will close within the year. But meanwhile a thick layer of skin covers it to protect the brain. It will not hurt to touch it.

2. The eyes may be puffy. Fairskinned babies usually have eyes that look blue-gray, while dark-skinned babies may be brown. These colors will probably change in the next few weeks. The eyesmay be crossed, but they usually straighten out in a few months. This is a result of the lack of coordination. The tear glands do not work immediately so the baby will cry without tears.

3. The face may look funny also. The nose may be flat or crooked because of the birth process. This,plus the small chin of the newborn,facilitates the sucking process needed to get milk.

4. The body is more developed in the upper half. The chest and shoulders are broad while the hips are narrow. The legs may also appear crooked.

* Babies tend to fold their arms and legs in a tucked position very much the way they stayed inside the womb.

5. The umbilical cord was tied off at birth. There is a small darkened 'tag' of skin tissue at the belly button. As it dries it will fall off by itself. It is essential to keep the cord area clean and dry. Wipe with some alcohol a few times a day.
6. Gentials; In the newborn, the breasts and genitals of both sexes may be swollen. This is due to hormones while the baby was in the womb. Sometimes the breasts may secrete a little milky substance and sometimes there may be a vaginal discharge. Always wash in the direction front to back.

If the baby is not circumcised, the mother should be instructed on how to retract the foreskin in order to clean the penis.
7. Some newborns are born with hair and fuzz all over their body. This will eventually rub off and does not grow back.

B. Physical Patterns:

1. Sucking- Babies swallow and suck while they are still in the uterus. This is the only way the baby can get food. It is important to understand that sucking makes the baby feel HAPPY and relaxed. It would be a positive thing to allow the baby to suck his thumb or use a pacifier. Emphasize that this is natural for the baby- so that the young mother does not pull it out.

2. Sight- The newborn does not focus its eyes very well. But it can see bright colors, light and shapes. Babies enjoy looking at these- especially the sight of a human face.
(You may want to recommend an activity such as a paper plate mobile with a face drawn on it.)

3. Hearing- The new infant can hear very well. Research has shown that the newborn can recognize its own mother's voice almost immediately. Avoid loud, sudden noises. They tend to

frighten. Try not to argue or fight in front of the baby.

4. Touching- Cuddling and touching are major means of communication. As was mentioned in the sixth objective,; babies need to be touched, stroked and held in order to develop into happy babies. A baby 'learns' by touch.

5. The sense of smell is also highly developed. Similar to hearing, the baby can recognize its mother(or whoever is the caretaker) by her smell.

6. Automatic Reflexes- The newborn will move hand to mouth, suck fingers, grasp very strongly and move its hand in a circle. If you stood the baby up on its legs(do not put weight on them), the baby would appear to be walking or moving them. The baby will turn its head and if placed on its stomach, it will try and lift it up.

* Emphasize the adjustments a newborn must make after birth. All systems have transferred from a 'water existance ' to an ' air environment'. Some babies may have difficulty swallowing, breathing, and sucking. Tests such as the APGAR determine any distress and the PKU TEST, to determine and prevent the possibility of a retardation factor, are done on the newborn infant at the time of birth.

C. Social Patterns:

Babies are individuals and they respond differently in different situations. It is important for the parent to recognize and accept these differences early so they can deal with less stress during those first few weeks and months.

1. The newborn is aware of pain and temperature change.

2. The newborn likes soft, high-pitched voices and will usually quiet down when it hears them.

3. The infant will smile and turn to the sound of familiar voices.

4. The new baby can be distracted when it fusses because it is becoming more interested in things outside itself.

5. The newborn is sensitive to the feelings of others and may become tense if it senses that the mother or father is tense.

PRACTITIONER INFORMATION

OBJECTIVE EIGHT

A. It is a common misbelief that picking up a crying baby will result in it being spoiled. Research shows that the OPPOSITE is actually true.

B. It is important for the practitioner to emphasize to the young mother that crying is the baby's way of talking.

C. A baby learns to trust its mother because the mother answers its needs completely. (Erikson)

D. A baby who doesn't get fed when it is hungry or held when it is afraid will feel that the world is an unhappy place. It will feel badly about others and itself.

E. If a baby is picked up PROMPTLY when it cries, by the time it is a year old it will cry less, develop trust, and communicate in ways other than crying. RESEARCH HAS ATTESTED TO THIS.

F. Repeat the concept numerous times throughout contacts with the teen mother. This mothering technique is a vital part of positive development.

G. The baby does not talk. It communicates its needs by crying. It calls parents by crying. It tells if the diaper is wet, if the baby is hungry, in pain or overtired.

H. Check out the usual problems, such as scratchy sheets, clothes etc. Then try some of the following methods:

1. rock the baby in your arms or carriage
2. use a baby swing
3. sing to the baby
4. hold the baby and walk with it while talking softly.
5. gently pat its back in rhythm
6. wrap it snugly in a blanket to give it a sense of security

7. If it is during dinner hour or during the day place the baby in the center of family activity to distract it.

8. Provide pacifier

9. If it appears to be stomach cramps or "colic", a warm compress to the stomach may ease them. Smaller feedings more often may help.

I. Sometimes babies will cry alot during the first few months NO MATTER WHAT YOU DO. This type of "colic" may be due to the fact that the baby's nervous system is still immature This may cause irritability and restlessness. This kind of crying usually goes away by the time the baby is three months old.

J. Practitioners should be sure to stress that the baby at this point may just need to cry itself to sleep. There will be times when the teenage mother will feel frustrated and angry toward the baby.

K. Help the young mother to understand that these feelings are normal and if she feels she may get OUT OF CONTROL, -provide her with alternatives.

1. first she must know NEVER to spank or hit an infant

2. The mother must never SHAKE the baby because it can cause severe damage to the brain.

3. Have her set up a support network BEFORE the baby is born. Select friends, relatives, boyfriend or husband etc. who can step in and take over. It must be someone who understands a baby's needs and who will not hit or abuse the baby.

PRACTITIONER INFORMATION

OBJECTIVE NINE

A. Feeding Patterns

1. Feeding time should be done in a relaxed atmosphere. The decision to breastfeed or bottlefeed is less important than the feeding environment.

2. Babies who feel their needs are met become more trusting of the parent. Emphasize the individuality of the baby. (babies do not all look alike nor do they all eat or sleep alike)

3. The first few weeks will show changing patterns from on day to the next. These will eventually fall into a more consistent one.

4. It is best to start by feeding on DEMAND. Some babies are smaller and need more frequent feedings in the beginning. (some as frequent as every two hours.)

5. By six weeks of age many babies are ready to give up their middle- of-the- night feeding. Do NOT cut down on the amount of milk- add that feeding on to the daily intake.

6. Never prop a bottle for the baby to drink alone.

a. The baby can choke or not get enough food which will cause distress and frustration.

b. The baby needs to be held. This is better for the baby's security and developing a positive mother-child relationship.

7. The consensus from the medical profession, at the time of this writing, is to introduce food later on in infancy. It is felt that early introduction of food may produce allergies. Around four or five months of age is preferred.

8. The most common and easily digested first foods include ripe mashed bananas, baby cereal and applesauce.

9. Always start by giving the baby a taste. Work up to a few tablespoons. Sometimes babies will spit out food just to get the feel of the texture and taste.

Emphasize that it takes a while for a baby to develop a taste for a specific food. Do NOT FORCE the food. Have patience. Give the baby time. Add only one new food a week.

10. Vitamins may be prescribed by the doctor.

11. Babies usually like foods served warm.

12. There are times when the feeding schedule may change again. This can be due to a growth spurt, teething or illness. Many times the baby may need to feed every hour or two, instead of the usual three or four.

13. Once teeth begin to appear it is important NOT to give a night bottle of milk to the baby for sleeping. This is because the milk left on the teeth during the night may rot out the teeth. It is best to cleanse the mouth with water before sleep or give a water bottle instead.

B. Sleep Patterns

1. Babies are individuals. Some may sleep 18 to 20 hours, while others may sleep much less.

2. Some sleep during the day and stay awake to play at night.

3. Usually it takes a few weeks for the newborn to settle into a schedule.

4. Emphasize to the student that the size of the baby may affect this pattern. A smaller baby may need to eat every two hours; Therefore that baby will be up more through the night

until its growth spurt has subsided.

5. Vary the position of the baby when it is placed into the crib. This will avoid the flattening of the head or the wearing off of hair. (This condition,if it occurred, would be strictly temporary. Hair and head do return to normal)

6. Avoid placing the baby in a bed with another person. That person could roll over on the baby.

PRACTITIONER INFORMATION

OBJECTIVE TEN

A. The most important purchase is that of the crib.

1.Stress the importance of purchasing a full-size one (not bassinet or cradle)

2. Stress the safety factor of having the bars no more than 2 3/8 inches apart. Babies can get heads caught in anything larger. (Beware of second hand cribs which are not up to specification

3. The crib should be accompanied by at least three sheets, mattress pads and receiving blankets.

4. A crib bumper guard also adds to the comfort of the baby and provides decoration for viewing.

B..Bathing the Infant

1. The mother should test the temperature of the bath water with her elbow because it is more sensitive than the hand.

2. The skin must be kept fresh and clean; But until the cord comes off, it is best to give a sponge bath. (The area around the belly button can be cleansed with alcohol. Keep the diaper below the cord so it can remain dry. It will heal better.)

3. Singing, talking and massaging the baby will make it fell more relaxed.

* If the student is interested in pursuing baby massage as a technique for providing loving contact for the baby and for developing the baby's alertness, such a course is given at the Family Center of Nova University. This is based on such

theories as the one from Frederick Leboyer's " LOVING HANDS : THE TRADITIONAL INDIAN ART OF BABY MASSAGE".

4. When sponge bathing, use a soft washcloth and plain water. Wipe each eye with a fresh cottonball dipped in lukewarm water.

5. Use a safety hold when washing the baby in the tub. Slip a hand under the baby's shoulder, with the thumb over the shoulder and fingers gently under the armpit. Keep head OUT of the water.

6. Soap the front of the baby's body carefully washing inside all skin folds and creases. Then rinse and reverse hold in order to do the back.

7. The genital area should be cleansed also. If there is still some whitish substance in external folds of the baby girl, a little baby oil on some cotton will wipe it away.
* Make sure that all wiping is done from the FRONT to the back.

8. " Do not put anything smaller than your elbow in a baby's ear" is a saying with truth. It is important to stress the fact that ears and noses should not be probed. Eardrums can be damaged.

9. Use powder (preferably cornstarch powder- talc can irritate baby's lungs.) and lotions with discretion. Some skins may be allergic to the perfume.

10. Important Fact: NEVER LEAVE A BABY ALONE IN THE BATH. Even if the doorbell rings, wait to answer. The baby can drown in minutes.

C. Outfitting the Baby

4 dozen cloth diapers or cases of disposible diapers

4 to 6 soft shirts (they can be larger)

3 - 4 soft nighgowns or sleepers

3 bibs

2 sweaters

2 - 4 terry towels (and washcloths)

comb and brush set

fingernail scissors

D. Equipment

crib

playpen or portocrib

infant car seat- government regulation

diaper pail

baby carrier (to free hands)

Infant toys and mobile (to be discussed in next chapter)

dresser

If you can't afford a changing table, use the bed or floor. But make sure that at any place, the baby is not left alone. The infant can roll off easily. One never knows the day a baby will start to turn over.

infant thermometer

Rocking chair is an extra. But a great comforter and help when feeding or soothing the baby

PRACTITIONER INFORMATION

OBJECTIVE ELEVEN

A. Health Care

1. Use a rectal thermometer. Shake it until the temperature shows below 96^0 F. Put a little vaseline on the tip. Place baby over your lap on its stomach and gently insert the thermometer no more than 1 inch. Hold it in place for two or three minutes in order to get an accurate reading.

* Tempa- dots are disposable thermometers to be used for taking underarm temperature.

2. Babies have a tendency to run higher fevers than adults. Call the doctor if the temperature reaches 102^0 F or more. A baby with no temperature can be ill. Watch signs as to how the baby looks and acts.

3. It is important to give the baby regular check-ups with the doctor or clinic.

4. The mother must keep a record of the baby's shots.

a. Diptheria, Whooping Cough (pertussis) and Tetanus are given together when the baby is 2 months old, 4 months and 6 months old. The baby will need booster shots again when it is 18 months old and 5 years old.

b. Oral Polio Vaccine is usually given in drops at the same time as the DPT shots.

c. Measles, Rubella (German Measles) and Mumps are given when the baby is between 1 year and a year and a half

5. Diarrhea can be a dangerous condition for the baby because

the baby can lose too much fluid. Diarrhea is watery, thin and foul-smelling. Movements can occur more often than usual. (Breastfed babies have frequent movement also, but this is normal for them.) A severe case may show in the appearance of the eyes, which may be sunken or have circles. The skin may be warm and dry. CALL THE DOCTOR.

6. New babies may spit up during the first few weeks, This is normal. But to minimize this, emphasize the gentle handling of the baby. Make sure the baby is burped more frequently and perhaps give the infant frequent, smaller feedings.

7. Colds are more common in infancy. Keep the room quiet and humid. A vaporizer is a good way to do this. A stuffy or runny nose makes it difficult for the baby to sleep or nurse. An ear or nose syringe (a tube with a rubber bulb) can draw out some of the mucus. Warm water or a little baby oil can wipe away dried and crusted mucus around the outside of the nasal opening.

8. Rashes

a. Babies may have face rashes during the first few months of life. These go away without treatment.

b. Diaper rash is due to excessive wetting or irritation from the introduction of new foods. The skin can also develop rashes from being in a wet or soiled diaper too long. It is important to change the diaper frequently. It is also helpful to allow the skin to be exposed to the air for several hours. Use of a mild cream such as Desitin or A.D. ointment will help heal and prevent reoccurances. If it persists, a doctor is needed.

c. Impetigo- small pus blisters are surrounded by reddened skin, This may be an indication of infection. It is very contagious and can spread. A doctor should be called immediately.

9. Cradle Cap- Crusted patches on the scalp in the early weeks. this can be cleaned with baby oil

10. Birthmarks-'Strawberry'marks usually disappear as the baby grows older.

11. Doctor to be called:

when there is an accident involving head injuries
or excessive bleeding
poisoning
difficulty breathing
diaper is exceptionally dry for long periods
rashes that are chronic or pus-filled
vomiting
a bulge or sinking in at the fontanel (soft-spot)
earache
convulsions
fever at 102 0 F. or over
severe diarrhea
appears unusually fussy or listless. Loss of appetite or seems just 'sick'.

B. Safety Care:

It is important to stress to the mother that no matter how careful you are about " baby-proofing " the house and providing a 'safe' environment; there is nothing safer than having the PRESENCE of a parent or adult.

1. Do not leave the baby alone in the tub.

Do not leave the baby alone on the changing table or bed.

Do not leave the baby alone with a propped up bottle.

Do not leave the baby alone to explore or crawl without a watchful eye.

Do not leave the baby alone in a car.

2. Make sure the milk isn't too hot by shaking a few drops on your wrist.

3. Make sure all small and sharp things are kept out of reach such as pins, buttons, coins etc.

4. Don't use plastic bags to protect the crib mattress or pillows.

5. Make sure all medicines, cleaning materials, polishes, (even baby powder), matches and other poisons out of reach. * purchasing little baby locks for the cabinets are an inexpensive investment .

6. Make sure the bath water is lukewarm. (check with elbow)

7. Make sure toys do not have cords, strings or loose buttons, sharp edges which can hurt the baby.

8. Make sure baby is strapped into car seat, swing or babyseat.

9 Electrical outlets should be covered.

10. Make sure all pot handles are turned inward so they are out of reach when cooking.

CHILD DEVELOPMENT AND PARENTING

INTRODUCTION

The identification of developmental stages of growth aid the young mother in achieving a better understanding of the baby's needs and actions. This knowledge allows the young mother to detach herself from personalizing the reactions the baby may have toward her; thus eliminating unwarranted hurt feelings or negative responses on the part of the mother. When a two year old says "no" to his mother or a 15 month old pushes away the mother and crawls off her lap, a knowledgable parent knows that such action is not a challenge to her power or a rejection of her, but a NEED on the baby's part for independence and exploration.

Teenagers are particularly sensitive. Therefore it is imperative that the baby's actions are interpreted correctly- as needs brought on by social and emotional growth. If this is understood, the nurturing will continue and excessive physical discipline or rejection will be eliminated.

PART THREE

OBJECTIVES

12. The young mother will be able to identify the changes in development (social, physical, language) with each stage of the baby up to the toddler stage.

13. The mother will know how to stimulate the baby so that its developmental and cognitive growth will be positively affected.

14. The mother will explore various forms of discipline in relation to situational episodes such as toilet training.

PRACTITIONER INFORMATION

OBJECTIVE TWELVE

A. The newborn can see simple patterns, follow slow-moving objects and loves to look at faces. The newborn responds by reflex (automatic) movement. Hand goes to mouth and the grip is strong. Newborns can express themselves only with crying. Stress to the young mother that this is the baby's only form of communication. There is no speech, but the mother should be encouraged to talk and sing to the baby at every opportunity.

B. By the age of two months, the baby can lift its head and try to move around the crib. The baby will suck fingers, gurgle and coo when the mother talks. The baby is more interested in things outside itself. The baby will turn to the sound of familiar voices.

C. By the age of four months old, the baby can hold its head steady and enjoy splashing in the bath. Some babies may start to teethe at this time. The four month old likes to look at fingers and hands. This baby loves attention and the company of family members. It also can laugh out loud.

D. At 7 months old, the baby has accomplished much. There is more control over the body. Some babies have begun to crawl and even pull themselves up to stand. They can hold toys and pieces of food. Some may start to say word sounds. The baby at this time will start to imitate the speech sounds of the parent. This baby will become more attached to the parent.

E. At nine and ten months old the baby is extremely social.

It responds to games like " Pat-a- Cake ", waving bye-bye, and " Peek-a- Boo ". This last game is significant because it is a game that eases the anxiety of having the parent ' disappear ' or leave the baby's sight. This baby may speak simple words such as 'mama' and 'dada' and walk with help. Babies at this age also enjoy looking at picture books. A baby may cry when a 'stranger' comes into the baby's view. Explain that this is a normal occurrance and the teen mother should not be embarassed or blame the baby.

F. By the time the baby is <u>one year old</u>, motor skills develop at a rapid rate. The baby at this age can feed itself and climb on furniture, cabinets and stairs. Mothers-to-be should understand that this is an age in which ACCIDENTS can occur. Portable folding gates for the stairs is a worthy investment which easily prevents the baby from climbing and ultimately falling down the stairs. It also limits the baby's access to other parts of the house. Babies like to throw things down from the high chair again and again to have mother return them. The baby is very social and shows a sense of humor. The baby likes to imitate. Learning so much at one time can cause the baby to feel frustrated and over-tired. The one year old needs comforting when that occurs.

G. Between <u>one year and two years</u> old is rapid acceleration in all areas of growth. The toddler may develop a vocabulary beyond two hundred and fifty words. Some babies even start using sentences. They use the words 'me' and 'mine' and have difficulty sharing toys. This is natural. The toddler

at this time can walk and run, eat with a spoon or fork, and take off shoes and hats. The toddler likes to 'control' things such as closing doors, flushing toilets, etc. The growing need for independence leads to the toddler refusing food or simple orders. The mother is being tested. The baby loves to say 'no'. The baby will still, if not more so, be fearful of strangers and not like being separated when mommy goes off to school or work. The baby will cry and throw temper tantrums more often. Some babies may develop attachments to a particular toy or blanket for comfort.

OBJECTIVE THIRTEEN

Stimulation involves interaction. The teenage mother should be made aware of the fact that encouraging alertness and "brain- power" takes time and contact with the baby. A child left in the playpen all the time, or left in front of the television all the time will not develop the attribute of curiosity or the desire to 'explore' which is associated with higher intelligence.

The teenager must understand that 'playing' and 'talking' with the baby is NOT a waste of time but an integral part of " mothering". It is this time of life which charts the course of emotional, social, intellectual and even physical development.

A. Activities for the time period between newborn and four months encourage the development of the grasping reflex and visual coordination. Babies at this age try to coordinate what they hear with what they see. Faces and colors interest them.

1. Purchase or make your own mobile. Figures should be especially expressive and colorful. They should move easily. Suspend them from the crib.----Variation: Use a pinwheel to blow for movement or attach it to the stroller.

2. Mother should sing daily to baby and perhaps rock baby in time to music. Interactions should be face to face so the baby can see expressions.

3. Cradle gyms are a good way for a baby to grasp what it sees. It exercises arms and finger muscles.--- Variation: Hang kitchen utensils such as light, plastic measuring spoons,

plastic lids, and colorful ribbons of different texture (lace, velvet, satin, etc.) which are looped for grabbing and batting.

4. To encourage interest in different sounds, the mother can crinkle a variety of paper, cellophane, foil in front of baby.

5. Hang pictures or photos of mother, sibling, family members, baby and simple animals such as a cat or dog. Name them to the baby.

6. Music accompanied with movement such as a chime ball or stuffed animals, make good toys.

B. Children in the sensory-motor period between the ages of five months to eight months discover with their mouths as well as eyes, ears and touch. They are more physical. Some sit up and therefore have more freedom to explore, crawl and reach.

1. Provide the baby with a variety of mouth and teething toys with bumps and groves on them. (It feels so good to the gums). These shapes should be easy to hold. Let the tongue and lips explore.

2. A busy box which can be purchased commercially has objects that can be manipulated. It provides eye-hand coordination as well as surprises and excitment. This is good for the baby who can sit on its own.

3. Textured blocks or books are good for touching. Pick one up and touch it. Say " smooth" or " rough ", etc.. Then give it to the baby to feel.

4. Baby should have access to pots and pans for a variety of banging experiences. Babies need to do this. The mother can provide the material she wants the baby to use. These materials should have no sharp edges or break easily.

5. The baby feels it can make things happen. Since the baby can sit up, a ball rolling back and forth is an excellent.

6. Babies like to move and bounce. Providing a walker to strenghten leg muscles (be careful it does not tip or catch little fingers. Watch for safety regulations on them). Bounce baby on your knees as well.

7.Water activities give baby experiences with texture , liquid and movement. Include a variety of floating toys to push down in the water. Experience develops language. Use words like 'wet','float' and 'swims'.

8. Babies can recognize their image in the mirror. Provide hand mirrors (unbreakable ones such as ones made by Fischer-Price.) as well as full length ones to establish body image. Point and name parts of the face and body.

9. At eight months of age baby expresses attachment behavior. Play peek-a-boo games behind blankets, with dolls, and with own image in the mirror.

C. Intergration and coordination of the motor with the visual and perceptual concepts take place between the ages of 8 months to a year old. Babies are interested in words, people and movement.

1. Baby can manipulate fine (small) motor movements. The baby enjoys putting things into containers and taking them out. Commercial stacking and nesting toys are available. The mother can provide baby with plastic stacking measuring cups.

Large wooden beads (too big to be swallowed) can be spilled out and placed into containers.

2. Babies think they have more balance when walking while holding onto an object. Push and pull toys are good for beginner walkers.

3. Language development continues to accelerate, Provide large picture books and such texture books as "Pat the Bunny". Take baby to the petting section of the zoo.

4. Babies can recognize a familiar object even though part of it is covered. You can partially hide a variety of things such as dolls, toys, spoons, etc. and then ask the baby to find what you name.

5. Babies like to crawl, stand and climb. Make a 'pillow room'. Spread a variety of pillows and cushions on the floor. Have baby climb or walk over them. Make a game of it by providing a reward or goal at the end of the course.

D. The ages between one and two years old are exciting and demanding for the baby. It is difficult for the toddler to stop and relax. There is too much to see, do, explore and learn. It is important for the parent to try and " direct " this energy.

1. Trips to the store and helping with purchases of cereal boxes, etc. aid in development of language. Visits to zoos, farms, etc. allow for the baby to move and run freely in a space without being too confined, yet provide a learning experience. The mother does not have to be concerned at these places about 'too much noise'.

2. Take advantage of the toddler's desire to pick up and move things by having the baby help with household chores

such as picking up papers and putting them in the wastebasket. Know that all such activities must be directed. The toddler does not have the maturity to continue projects on its own for long periods of time.

3. Matching socks or handing you items that you call by name from sorting laundry is shared activity and good for language development. Don't be surprised if any of these activities last only for a short time (a few minutes). It's hard for a toddler to keep still. Their motors are always running.

4. Read picture books together. A good time is before a nap or at bedtime. It is an activity that will help settle down the toddler.

PRACTITIONER INFORMATION

OBJECTIVE : FOURTEEN

Young parents may have disappointments concerning expectations of how the baby looks, its personality, its sex and the fact that it may be handicapped. If the mother can accept differences that cannot be changed and concentrate on the love and care for the child, parenting takes on a more positive meaning.

Young teenagers question their abilities. They feel unsure. It is important that the mother understand that unless she feels happy and respects herself, she CANNOT bring love to the child.
* It is recommended that the practitioner use dialogue to promote positive self-worth, development of goals, and respect for one's own culture. These are important confidence builders which lead to good parenting.

A. Simple Rules to Remember:

1. Mistakes give you a chance to grow and learn. It's a waste of time to lean hard on yourself.

2. Concentrate on only the things you do well.

3. Even if your parents may have done things differently or you did not like what they did- pick out how you would have liked to be treated and DO that with your own child.

4. To be a good parent means there are certain things that you MUST do. You are responsible to take care of the baby EMOTIONALLY AND PHYSICALLY. A baby needs love, help to learn as well as a safe place to live, food and clothing.

5. Learn to accept your baby the way he is. It is natural

to be disappointed about some things. No one in this world is perfect. DO NOT EXPECT TOO MUCH TOO SOON. A baby cannot be toilet trained at one year of age. His body isn't ready yet. If you try to make your baby do things before it is ready, you will get frustrated, sad and angry. This will also make the BABY feel that way too.

6. Do things for yourself. Take time to relax alone and eat well. Take good care of yourself. If you feel good about yourself, you will feel good about the baby.

7. Plan ahead. Figure out how you are going to handle problems BEFORE they happen. That way you wont react with just feelings and lose your temper.

8. Plan on having someone available to take over. This should be someone you can TRUST. This is important. A mother needs time to be away from the baby once in awhile. It is also important to have someone who will give you SUPPORT if you are having a bad time of it. It is normal to have periods where it is hard to handle the baby. ASK THAT PERSON FOR HELP.

B. Babies do certain things:

1. Babies are DISTRACTIBLE. They will play with one toy or object, but when another thing comes in sight, they will drop what they are doing and start something new.

2. Babies like to have control of their lives. They will drop things on the floor and have mommy keep picking them up. They love this game.

3. Older babies will cry and fight to go to sleep at night. They may have fear of separation. They are afraid to leave mommy. These fears may show up in visits to a doctor or dental office or even a trip to grandma.

4. Older babies like to feel they are growing up. THEY WANT TO DO THINGS ON THEIR OWN. They will say " NO" alot. They will do the opposite of what you ask them---automatically. This baby is not naughty. The baby cannot help himself . It is part of the need to grow up.

5. The baby needs physical space and room to explore. The baby needs to try out muscles and walk, climb, open doors and drawers. STAYING IN THE PLAYPEN TOO LONG IS FRUSTRATING FOR THE BABY. Moving is how a baby LEARNS.

6. Children love to imitate. This is also how they learn. If they are hugged and kissed alot they will be more inclined to return them. If a child is slapped around alot that child will hit, punch and kick to get what it wants. Behavior can become aggressive. Studies have shown this to be true.

C. What can a mother do?:

THE BABY TOUCHES SOMETHING OR GRABS SOMETHING YOU DON"T WANT HIM TO HAVE.

1. You can say "no" firmly. But don't expect the baby to stop and listen. You must say "no" and at the same time trade the item for something else safe that will interest the baby. You can distract the baby by giving him something else quickly that is interesting and safe.

2. You can prevent problems by keeping certain things you don't want touched ' out of reach ' or locked up. You can't say no ALL the time. " Child-Proof " the house.

THE BABY KEEPS CALLING YOU OVER TO THE CRIB TO PICK UP TOYS HE HAS DROPPED OUT.

1. If you don't want to play this game, you can remove him from the crib or high chair and place him on the floor with the toys. There is no place to 'drop' them.

2. If you cannot leave him crawling on the floor, you can attach the toys to the crib with a very short (about 1 foot) string so that they cannot fall on the floor. It must be short enough so it will not tangle the baby.

THE BABY CLIMBS ALL OVER THE COUCH WITH HER SHOES AND PULLS DOWN THE CUSHIONS'

1. You can take off her shoes and still let her climb over the couch if it is no longer damaging to the couch. (Remember, babies need physical activity.)

2. You can provide a " pillow corner" in the room for the baby to climb. Have limited space set aside in the house for these kinds of activities.

3. You can provide some climbing toys out in the backyard if that is possible or take her to the park or playground to get rid of some energy.

4. You may be able to distract her with another game or toy.

THE BABY REFUSES TO GO INTO THE HOUSE WHEN YOU ASK- " ARE YOU READY TO GO IN AND HAVE DINNER NOW?"

1. Don't ask a baby. They have to say "no". It is their nature at this time. Tell them " It is time to go in now". (and physically lead them as you are speaking)

2. Sometimes you can get a toddler to cooperate by giving them a choice BETWEEN TWO PERMITTED ACTIVITIES. For example the mother can say; " You can go in and have dinner or you can go in and take a bath. Which do you want to do?"

THE BABY IS DOING SOMETHING THAT ANNOYS YOU.

1. Sometimes children will do something to get attention. You can stop behavior by removing the child from the situation. (Remember, toddlers like to do the opposite of what you want.)

2. You can choose to ignore the behavior and it will stop because the child is not getting your attention.

3. Give lots of praise and affection when the child is doing something good. This is GOOD attention. Children want to please their parents.

THE BABY WILL NOT GO TO SLEEP OR IS AFRAID TO GO TO THE DOCTOR'S OFFICE OR ON A TRIP.

1.A toddler needs time to adjust to changes. Prepare the child for those changes. Give advanced notice and explain what will be happening when you go. Draw pictures if necessary.

2. If the baby is afraid to go to sleep, the mother can stay for awhile in the room until the baby does fall asleep. Don't keep jumping up. Plan to stay. If you do that it will

just postpone the sleep because the baby thinks you are leaving.

3. A nite-light or leaving the door opened or music can be comfort aids to ease sleep.

* 4. By providing varied experiences and being in the company of other people during babyhood, the toddler may feel more relaxed in new situations. This will lessen her anxiety. Don't isolate you both.

C. Toilet Training

1. Babies during the first year are not regular enough to be trained. The mother can have them sit on a potty after meals, if the baby seems regular. But understand that the baby is NOT trained the MOTHER is trained.

2. At one and a half years of age the baby understands what is happening but is afraid to give up the precious possession of her bowel movement. (The baby thinks it is part of her and belongs to her. They do not share well as yet.) Reassure the baby that she will be able to make another one the next day.

3. The best time for readiness is between the ages of 18 to 24 months old.

a. They have greater awareness and can notify the mother when they have soiled.

b. They may start to show an aversion or disgust to the smell and the discomfort or dirtiness of the movement.

4. Flatter the child's ability. Some parents offer new clothes or panties to reward efforts.

5. Make sure that the clothes are comfortable and easy to pull off and on in order to go to the bathroom.

6. Training pants are more helpful than diapers because they make the toddler more conscious of the need to control.

7. Urine training takes LONGER than bowel training. Many children are still wetting the bed at age 2½ and three years of age.

8. At the beginning of training a toddler may notify the parent AFTER it happens. One reason may be because the child is too busy playing to notice until it is too late.

9. Many average toddlers are affected by fears, upset stomachs, and the excitment of changes in their routines- such as trips, visits, movies, incidents at day care, parties, etc. These things can cause them to have ACCIDENTS and wet their beds or soil their pants.

PUNISHMENT ONLY MAKES THINGS WORSE. IGNORE THE ACCIDENT.

10. Encourage the toddler by telling him that he will do better tommorrow. Reassure him that you LOVE him even if he wets his bed or soils his clothes.

STUDENT ACTIVITIES

1. Write down everything you eat for three days.
Prepare a chart for checking each of the basic four food groups each day.
Afterwards check your diet. Decide how you would change it in order to eat properly for yourself and the baby.

****

2. Adopt an Egg project

If the student does not yet have a child of her own, this project may be quite interesting for her. It may help her with decisions concerning keeping the baby.

Provide the student with an uncooked egg. She is to take care of it as though it were a newborn baby.

She is to name the egg and paint a face on it as well as prepare a tiny box for it as a crib.

For one week, the egg must remain with the student. If the egg is left at home, a baby-sitter must be found and adequate care is given to her egg-baby. The student is to report back in one week.

****

3. Keep a diary of thoughts, feelings and questions about the pregnancy and its relation to family and friends and school.

When I need help, where do I go:

for school problems_____
for personal problems_____
for friend problems_____
for family problems_____

****

4. Describe infant care procedure in the hospital, after a film or trip to the hospital maternity unit.

****

5. Explain the process of menstuation, ovulation, fertilization after a discussion and/or viewing of films on that subject.
Note: How many sperm does it take to fertilize an egg?

Label a diagram of both the man's and woman's reproductive organs and their function.

****

6. Draw pictures of the embryo and fetus at various stages of development.

a. Role-play an unborn baby--imagine what it is like to be living inside another persons body- floating in a liquid.

b. Imagine what your baby looks like right now. Draw a picture of it or describe it.

****

7. Invite a midwife, Doctor of Obstetrics and nurse to discuss prenatal care and exam.

(PreNatal Care DHEW # OCD 73-17)

****

8. Have a store such as"Maternally Yours" lend clothes for modelling by the students. Include discussion on the correct fit for maternity bras and support attire.
(A sewing center such as Singer could also participate so the

students can make the clothes themselves.)

****

9. Invite a Dentist to talk about dental care for the pregnant woman.

****

10. Students can make posters about personal care. These can be cut out from magazines.

a. Question: What are the dangers from not gaining enough weight?

b. Why is it important to see a doctor early and regularly?

****

11. Invite a Doctor of Obstetrics, a representative from CEC or PACE to discuss anesthesia and childbirth.

Demonstrations of prenatal and postnatal exercises can be given.

****

12. List six things that are dangerous to the unborn child and tell how each might hurt the baby.

****

13. Make up a menu to include nutritious snacks for children:

at age 4 months-- 9 months--1 year----2½years

****

14. Respond to a letter:

" I had my baby 10 days ago. Most of the time I am very happy and feel real good. Sometimes I seem to cry for no reason at all. Is this normal? What can I do? "

****

15. Name 5 things a mother can do to help her body return to normal after childbirth.

****

16. What advice would you give a pregnant woman about each of the following:

rest	breasts	exercise
bathing	teeth	sexual relations
clothing	housework	douching

****

17. Make a baby mobile of a paper plate face to attach to the crib.

****

18. List the environmental factors that can affectthe food habits of a baby or young child.

****

19. List some things that can be put in a baby's room to help him develop.

****

20. Baby's first book: Find and paste pictures that a baby would be familiar with. Write down the name of each picture under it. Then try it out with a baby you know or at the day care center on a visit.

****

21. Touch and Feely Book:

a. Make a book with one picture on each page.

b. Draw a picture of an animal or object

c. Fill in your picture with a different thing on each page that would be good to feel.

d.Try it out on a baby.

e. Note which picture the baby liked the best.

F. Note how you felt while you were reading with the baby.

****

22. Estimate cost of delivering a baby :

childbirth	nursery furniture
maternity wardrobe	baby equipment and toys
disposible diapers	baby-sitters
baby's clothing	
food	
child care needs	
medical care	

****

23. Give a bathing demonstration using a doll.
Give a demonstration on feeding, taking the baby's temperature and diapering the infant.

****

24. Discuss ways to modify or change the home environment to provide a safe, secure and comfortable place.
Use pictures from a home design magazine to make the discussion more visual and less verbal.

****

25. Invite a panel of young unmarried or teenage mothers who have decided to keep their babies. Have students prepare questions.

****

26. Interview a parent of a toddler. Ask that person what are the most common problems, how the parent disciplines and how effective is it?

****

27. Debate: It is better for school-age parents to continue living with their own parents until they finish high school.

****

28. List six items found in most kitchens which could be dangerous for a toddler to handle.

****

29. Role-Play a toddler-------eating, sharing toys, etc.
Pretend you are a toddler and crawl through your house.
Look for things that might interest a toddler but may also be harmful.

****

30. Questions for discussion:

What is a good parent?
How does a parent show love to a child (verbal and non-verbal) ?
How can you teach your child to trust you when she is very young?
Is child's play a waste of time?

SAMPLE TECHNIQUES FOR THE SLOW READER

OR LEARNING DISABLED

1. All handouts or booklets should be read aloud together. This reinforces auditory memory, in case the visual short term memory is weak, and helps the student receive information through the other senses.

a. paraphrase some of the information, concentrating on the main idea.

b. Scan for fact or general information. eg. Tell the student to find the age a child should start toilet training from a written passage.

2. Visual clues are essential for memory of vocabulary.

a. divide word into syllables

b. color- code (divide word into syllables or groups and write each section of the word in a different color) eg. FETUS. ' FE' in red, the 'T' in green and the 'US' in black.

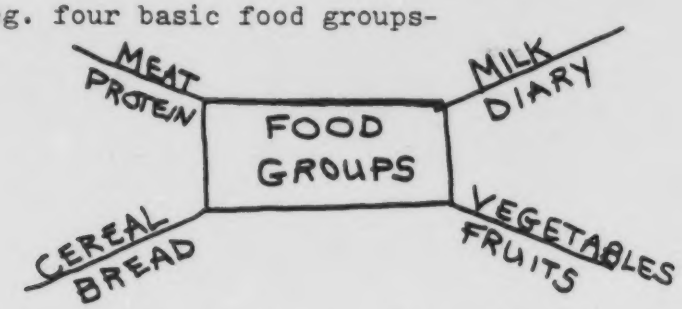
c. Diagram or outline the shape of the word. This clue helps with easier identification. eg. colostrum

3. It is not always necessary to be able to read or spell each word. It is more important to convey the function or meaning of the word. To use visualization of a word in order to aid the memory is a well known technique.

a. Have the student draw a picture next to the written word to show its meaning or " visualize " it in her mind.

b. eg. fetus= the unborn baby's feet touches us

4. Diagram a concept in order to make it concrete in memory. eg. four basic food groups-



5. One can take the same concepts and commit them to memory through a mnemonic technique which uses the first letter of each word to memorize a series by forming them into a word or a sentence.

eg. four food groups

M= MEAT	M= MY
M= MILK	M= MOTHER
F= FRUITS/ VEGETABLES	F= FLIES
C= CEREAL	C= CAREFULLY

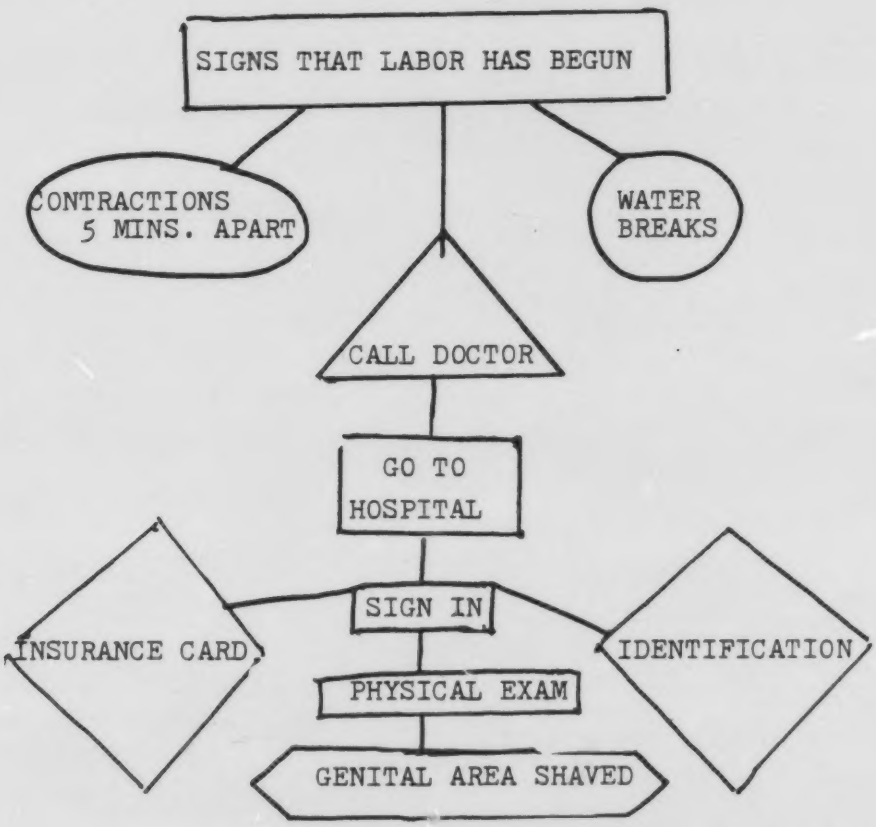
6. Classification is a technique which can aid conceptualized thinking. Have the student list or group words according to function (use) or attributes (the way something looks), or from simple to complex.

7. Alphabetizing is one of the simplest organizational patterns that can be used when trying to memorize a list. When presented with a randomly organized group of words, alphabetization can be used to aid the memorization process.

8. A flow chart is a helpful organizational tool. It is a diagram that connects step by step processes through connecting lines. It can be used to illustrate steps in a lesson. It is considered a means of 'thinking on paper'. It helps to break down steps or items. It can help a low achiever who has difficulty following lengthy verbal instructions or help pinpoint the cause of a problem.

eg. Have the student list steps related to the beginning of labor and the trip to the hospital. *

* The student should draw this out herself with the practitioner as a guide.



RESOURCE MATERIALS

FILMS --------FILMSTRIPS----------VISUAL AIDS

Parent's Magazine is a great source of visual aid. They have a variety of series of filmstrips and cassette that cover a multitude of subjects. They run approximately 12 minutes and are in color. Listed below are just a few of the areas available in this study area. Send away to get the complete listing.

PARENT'S MAGAZINE FILMS, INC.
52 VANDERBILT AVENUE
NEW YORK, NEW YORK 10017

1. Understanding Parenthood: The Economics of Parenthood

" Laying the Groundwork"
" Nine Months to Get Ready"
" Now there are Three "
" Baby Begins to Grow"
It's Time for School"

This is designed to aid couples in dealing with the financial responsibilities of parenthood .

2. Conflicts Between Parents and Children

"Daily Disagreements "
" Toileting Troubles "
" Dressing Disputes "
" Bathing Battles "
" Bedtime Bickering"
" Mealtime Misunderstandings "

This series of filmstrips emphasizes the concept that daily conflicts need not become destructive elements in a relationship.

3. The School-Age Parent: Dealing With Practical Problems Of Parenthood'.

" Reaching for Emotional Support "
" Finding Day Care "
"Prenatal Health Needs "
" Keeping the Baby Healthy "
" Family Planning "

These filmstrips offer guidance as to how the school-age parent can handle the day to day aspects of caring for a child. It also focuses on the school-age father and aspects of multi-culture.

4. Children in Crisis : Child Abuse and Neglect

" A Crippling Disease "
" Discipline Versus Abuse "
" Who is the Abuser? "
" How Can We Tell? "
" Treatment and Prevention "

Different kinds of child abuse are discussed. The series tries to help viewers understand the difference between disciplining and abusing. It is sensitive to the problems of parents and incorporates ideas for prevention.

****

PERENNIAL EDUCATION, INC
477 ROGER WILLIAMS
P O BOX 855 RAVINIA
HIGHLAND PARK, IL. 60035
PHONE: (312) 433-1610

1. Look At Me: The Working Mother 1978 . color

This film shows ways in which the working mother can enhance learning in her children through various activities.

2. The Big Dinner Table

This is a nutrition education film which illustrates how different foods are served all over the world and how each is composed of food from the four basic food groups

3. Look At Me: Everyday Parenting 1977 . Color 28 minutes

This film demonstrates to parents how everyday activities can be used to facilitate the growth and development of the young child.

4. Young,Single,and Pregnant . Color. 18 minutes

This is the story of four young women and the decisions they make with regard to their pregnancy.
adoption--abortion---marriage---single motherhood

****

The Amazing Newborn

Health Science Communication Center
Ross Laboratories----free loan

Portrays how the development of the newborn can help foster good early communication between parent and infant

****

Prenatal Care 24 minutes, color

Pyramid Films 1977
P O Box 1804
Santa Monica, Ca. 90406
Phone: (216) 541-1554

The film covers four aspects of prenatal care, doctor's care and preparation for birth. Very comprehensive.

****

Teenage Father 29 minutes color

Children's Home Society of California
Public Relations Dept.
3100 W. Adams Boulevard
Los Angeles, Ca. 90018

This is a realistic portrayal of an unmarried couple and their decisions about rearing a baby. Shows interaction between the boy and his friends as well as the girl and her parents.

****

Newborn. Free loan from Johnson and Johnson Products Inc.

Excellent film that covers the first two years of life'.

****

Jenny is a Good Thing 25 minutes color

National Audio Visual Center
Washington D.C. 20409

The film describes the effect of an adequate nutritional diet on a young girl from Head Start.

****

Inside My Mom 8 minutes, Filmstrip/cassette

National Chapter Foundation
March of Dimes

Good discussion starter. A cartoon fetus tells what it thinks about being with its mother and the nutrition she provides.

****

Educational Development Center
Exploring Childhood
55 Chapel Street
Newton, Ma. 02160

1. Bill and Suzi: New Parents 13 minutes. black and white

Young parents bring their infant daughter for a check-up.

2. Gabriel is Two Days Old . 15 minutes. black and white

Dission of what the baby is capable of at birth.

****

Bernita's Film 28 minutes 1976

Centre Films Inc.
1103 N. El Centro Ave.
Hollywood, Ca. 90038
Phone: (213 466-5123

The film shows how a black, unmarried teenager goes through her pregnancy, prenatal visits and Lamaze classes. The realistic struggles of parenting, feeding and doing the laundry are shown.

****

Having a Healthy Baby: Pregnancy 22 minutes. color

Indiana University, Audio Visual Center

NET Film Service

Bloomington, Indiana 47401

Phone: (812) 337-8087

This film shows fetal development through animation paralleled with mothers talking about their pregnancies.

****

Lynn and Smitty 16 minutes. color

Dr. N. Kendall

Temple University Hospital

Philadelphia. Pa. 19140

The film is narrated by a black couple concerning their own birth experience. Flashbacks are used to show prenatal care.

****

Birth Control: The Choices 25 minutes. color

Churchill Films

662 N. Robertson Blvd.

Los Angeles, Ca. 90069

Phone: (213) 657-5110

It explores all methods of birth control, their uses, limitations and side effects.

****

Accident Prevention.10 minutes

Sutherland Learning Ass. Inc.

14654 Oxnard St.

Van Nuys. Ca. 91411

Many kinds of preventable accidents are portrayed and discussed. Emphasis is on accident prevention for the very young.

****

We Were Just Too Young.

MTI Teleprograms Inc.

4825 N Scott St.
Schiller Park. IL. 60176

The film discusses the story of teenage parenting as a documentary with an actual family. Depicts sesitivity and realism as the film reveals frustrations and hardships.

****

Tomorrow's Families. Video series

Agency for Instructional Television

Box A

Bloomington, Indiana 47401

This is a series of thirty lessons designed to expose young people to pregnancy and child-bearing. It is presented in a soap opera format and tries to show that young people often have unrealistic ideas about parenthood and consequently do not make informed rational decisions.

****

RESOURCE MATERIALS

BOOKS----------MANUALS----------PAMPHLETS

Ashdown-Sharp, Patricia. A Guide To Pregnancy and Parenthood For Women on Their Own

1977. Pap. Vintage Books, Random House. New York

Details alternatives for the young pregnant mother.

Barr, Linda and Catherine Monserrat. Teenage Pregnancy: A New Beginning

1978. New Futures, Inc. 2120 Louisiana N.E. Albuquerque. NM

This is a book written especially for teenagers who are pregnant.

Bing, Elizabeth. Six Practical Lessons for an Easier Childbirth

1980. Bantam Books. New York

Crary, Elizabeth. Without Spanking or Spoiling: A Practical Approach to Toddler and Preschool Guidance

1979. Parenting Press. Seattle Wa.

Each chapter includes exercises designed to help parents solve real problems

Caveney, Sylvia. Inside Mom: An Illustrated Account of Conception Pregnancy, and Childbirth.

1977. Simon Stern. St. Matin's Press

Ideal text for pregnant teens who have difficulting following a hard to read textbook.

Frailberg, Selma The Magic Years.

1959 Charles Scribner's Sons. New York

Describes the personality development of a child during the first 18 months of life.

Gordon, Ira. Baby Learning Through Baby Play: A Parent's Guide for the First Two Years

1970 . St Matin.s Press

Excellent suggestions for simple play and learning experiences.

Geme, Joseph MD. Child Care

1973 Rocom Press Hoffman-LaRoche, Inc. New Jersey

This is a child care manual which includes chapters on feeding and growth. Some vocabulary is difficult but it is easy to read with bold print and pictures.

Gribben, Trish. Pajamas Don't Matter

1979. Jalmar Press Inc. Sacramento. Ca.

Covers important aspects of parenting. It is a good supplement.

Gordon, T. PET- Parent Effectiveness Training

1970 Peter H. Wyden, New York

This is a series of approaches to communication and discipline of the child

Dinkmeyer, D. Systematic Training for Effective Parenting: Parent's Handbook

American Guidance Service, Inc. Circle Pines, Minn. 55014

Color illustrations and charts makes concepts with regard to child discipline easy to understand.

Howard, Marion Only Human- Teenage Pregnancy and Parenthood

1979 Paper. Avon Books

An easily read story about three young couples expecting their first child. There are insights into feelings and concerns

** Koschnick, Kay. Having a Baby

1975 New Readers Press. Division of Laubach Literacy International box 131, Syracuse, New York. 13210

Chapters are available in separate pamphlets. The information presented covers aspects of pregnancy and medical infirmation. It is excellent ofr teens and is written on a 5th grade reading level. Some titles include "The first 6 weeks of Life" and " Unwed Mother".

**Keller, Rosanne. As a Child Grows

1979 New Readers Press Laubach Literacy Inc. New York

This book is a brief look at children from the newborn to five years of age. This is written on a second grade reading level.

** THESE BOOKS AND PUBLICATIONS ARE LOW LEVEL READING WITH HIGH INTEREST. THEY ARE PERFECT FOR THE SLOW STUDENT OR LEARNING DISABLED.

** Keller, Roseanne, When a Baby is New

1979 New Readers Press Laubach Literacy Inc. New York

These are three short selections written on a second grade reading level. They show how to diaper, feed and bathe the baby.

** Lally, Dr. J. Ronald and Dr. Ira Gordon. Learning Games For Infants and Toddlers.

1977 New Readers Press Laubach Literacy, Inc. New York

This is a playtime handbook containing activities for babies two months to two years.The author explains how games help children learn to use their bodies. The book is designed on a fifth grade reading level.

LaLeche League, The Womanly Art of Breastfeeding

1971 LaLeche International , Franklin Park, Il.

A concise book which covers all aspects of family adjustment to a new baby and the'how to' questions concerning feeding, breastfeeding, schedules etc. It has much information.

Leach, Penelope.Your Baby and Child from Birth to Age Five

1977. Alfred A. Knopf, New York

This is a beautiful book with much information and lovely photos and drawings. It is an outstanding guide.

Mayle, Peter Where Did I Come From? The Facts of Life Without Any Nonsense and With Illustrations.

1973 Lyle Stuart Inc. New Jersey

A funny book with cartoon-like illustrations

Rediehs, Pat Amanda the Panda Series,

Creative Living Associates, PO Box 1404 Maitland, Fla. 32751

This is a series of 'how to' take care of the baby from birth to 12 months. It is distributed every month through the Broward General Hospital. It is written on a fifth grade level and includes once a month rap sessions to provide support.

** THESE BOOKS AND PUBLICATIONS ARE LOW LEVEL READING WITH HIGH INTEREST. THEY ARE PERFECT FOR THE SLOW STUDENT OR LEARNING DISABLED.

Ridenour, Nina PHD Some Special Problems of Children Ages Two to Five

Child Study Association of America Inc. New York 10028

This book covers problems related to toilet training and sleeping and eating.

Salk, L. What Every Child Would Like his Parents to Know

1973 Warner Paperbacks, Warner Books, Inc. New York

Dr. Salk is convinced that parents can overcome future emotional problems by preventing them with the use of psychiatric principles in childrearing.

Segal, Marilyn Birth to One Year

1983 Mailman Family Press, White Plains, New York

This book has month by month descriptions of the baby's development with suggestions for games and activities. It is very well written and has excellent photos of the babies at each level. It is easy to follow and can be useful to the high school student.

Sofferini, Pam Life Styles- A Teaching Unit

Education and Counseling Program, Child Development Service
Lakeview Center, Inc. 1221 West Lakeview Ave. Pensacola, Fla. 32501

This unit covers various aspects of adolescent parenthood and peer relationships. It discusses the responsibilities such as financial, emotional and physical etc. with regard to being a parent. This unit is good for decision- making prior to pregnancy.

** Snowman, Margaret. Caring for a Child

New Readers Press Laubach Literacy Inc. New York

This book contains information on the care and feeding of children to the age of five years old. It covers emotional development as well as safety and health concerns. The reading level is 4.2

Spock, Benjamin, Baby and Child Care

1974. Pocketbook Edition Simon and Schuster, Inc. New York

This is a classic which covers all aspects of child care. It serves as a guide for the practtioner or parent.

** THESE BOOKS AND PUBLICATIONS ARE LOW LEVEL READING WITH HIGH INTEREST

Sheffield, Margaret Where Do Babies Come From? A Book For Children and Their Parents

1973 Alfred A. Knopf, New York.

This book was adapted from an award-winning BBC program used throughout the primary system. Beautiful paintings accompany the text which describes the conception and the birth process.

Wood, Phyllis Anderson Song of the Shaggy Canary

1976 Signet Book, New American Library, New York

This is the story of a teenage mother whose husband has walked out on her .It depicts her struggles to finish high school and and care for her son. In the end they find a new friend who changes their lives.

****

Other Sources

Lindsay, Jeam Warren. Teens Parenting

1981 Morning Glory Press, Buena Park Ca. 90620

This is a combination teacher's guide and booklet which poses a variety of questions which are excellent for use in rap sessions. It also provides lists of activities and resouce material.

****

Publications Catalog of the Department of Health, Education and Welfare

Superintendent of Documents
U. S. Government Printing Office
Washington, D.C. 20402

A list of publications can be obtained inexpensively on topics related to child development and parenting skills.

****

Johnson and Johnson Products Co., Skillman, New Jersey 08558

This company provides many free publications such as "Baby Care Basics" and " How Does Your Baby Grow "

****

STUDENT HANDOUTS

COMPILED FROM SOURCES MENTIONED IN THE BOOK AS WELL AS FROM AGENCIES SUCH AS BROWARD COUNTY SCHOOLS CURRICULUM ON CHILD CARE , SALVATION ARMY, MARCH OF DIMES, ETC.

First Four Months of Development

THE FIRST TWO WEEKS
Actual Size

FIRST and SECOND MONTH
Actual Size

THIRD and FOURTH MONTH
Actual Size

BEST COPY AVAILABLE

Fetal Development--
Fifth and Sixth Month

Actual Size

BEST COPY AVAILABLE

End of Ninth Month

You And The Baby Are What You Eat!

All of these foods are important for your health and the baby's growth.

Choose foods from each of the four food groups and drink lots of water every day.

PREPARATION FOR CHILDBIRTH PROGRAM

E

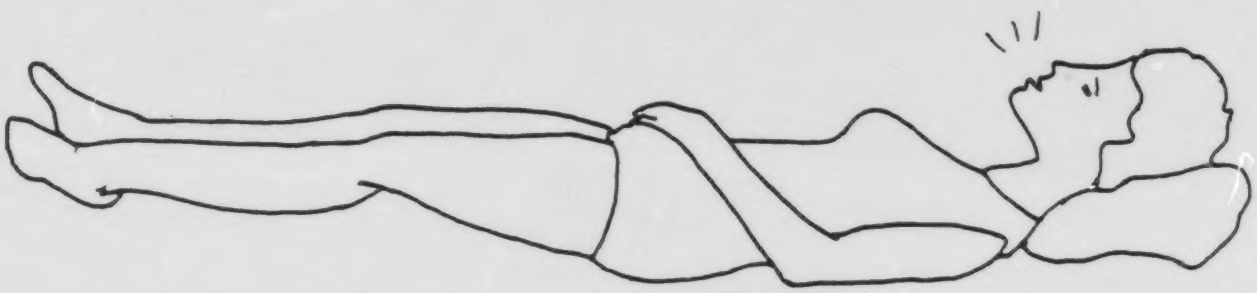
The Booth Maternity Center
Philadelphia, Pennsylvania

POST PARTUM EXERCISES*

There are two areas which need restoration following the birth of a baby. One is the abdominal muscles, which have been stretched to accomodate the growing uterus, and the other is the pelvic floor muscles. The latter muscles undergo increased elasticity by the hormones of pregnancy in preparation for the birth. Restoration exercises should begin as soon as you feel up to it, but if you have any question as to when to begin, consult your doctor. Do the exercises twice a day.

ABDOMINAL RESTORATION

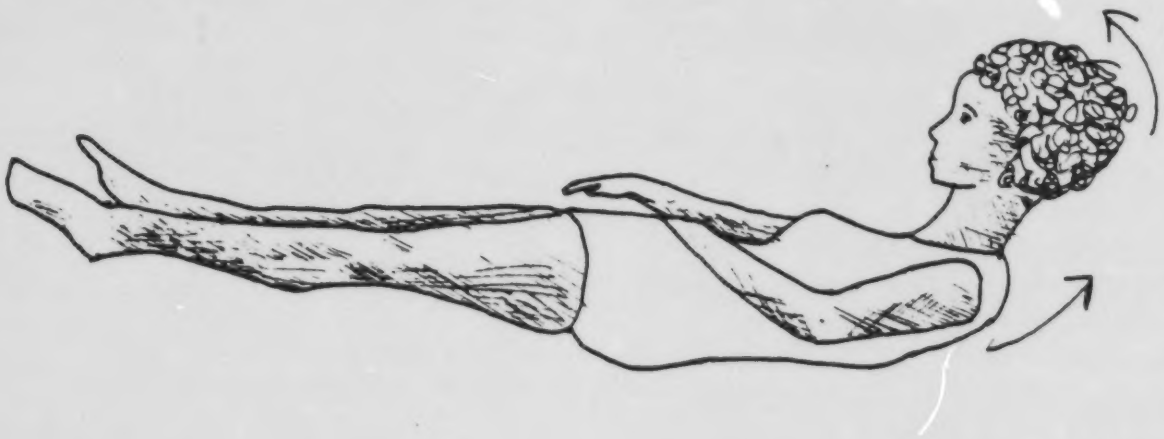
1. Abdominal Tightening - Take a deep breath in and slowly let your breath out through pursed lips, as though blowing a candle. As you are slowly blowing out, tighten your abdominal muscles as much as you can. This exercise may be practiced lying down, sitting, or standing. Repeat the exercise five times.



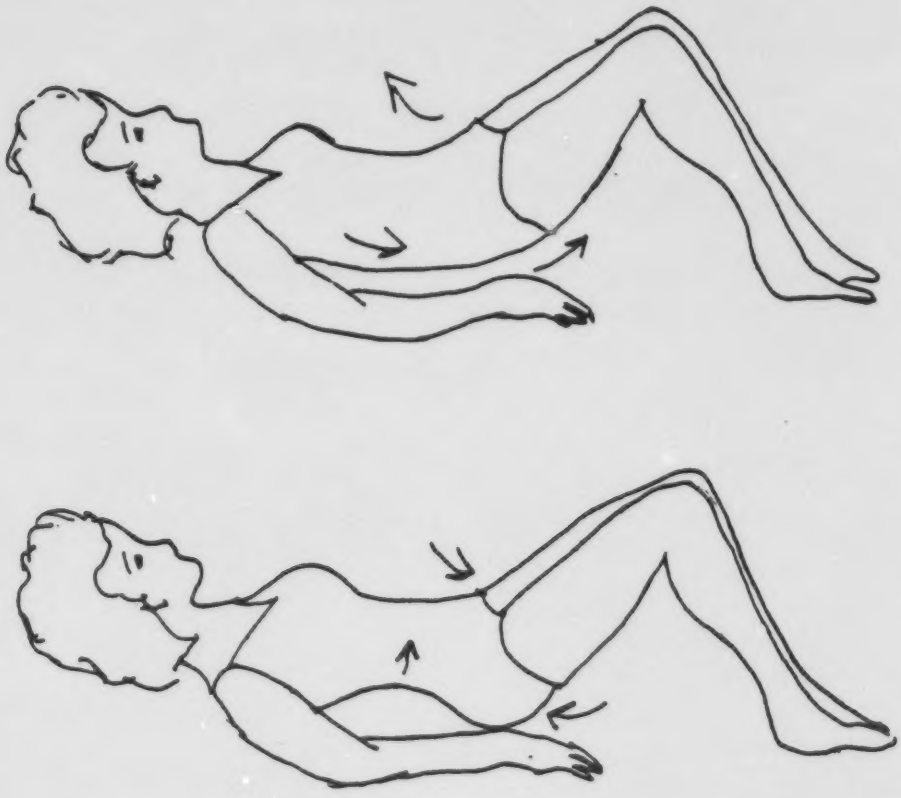
2. Chin to Chest - Place your bed flat and remove the pillow. Lying flat on your back, slowly life your head and touch your chin to your chest. Then slowly return your head to the bed. Place your fingertips on the lower abdominal muscles (below the navel and above the pubis) and feel the muscles tightening. Repeat the exercise five times.

*By permission of the Wilmington Medical Center.

3. Shoulder Elevation - Lying in the same position, now lift your head, shoulders, and arms off the bed and point your fingers in the direction of your toes. Slowly return your arms, shoulders, and head to the bed. Repeat five times.



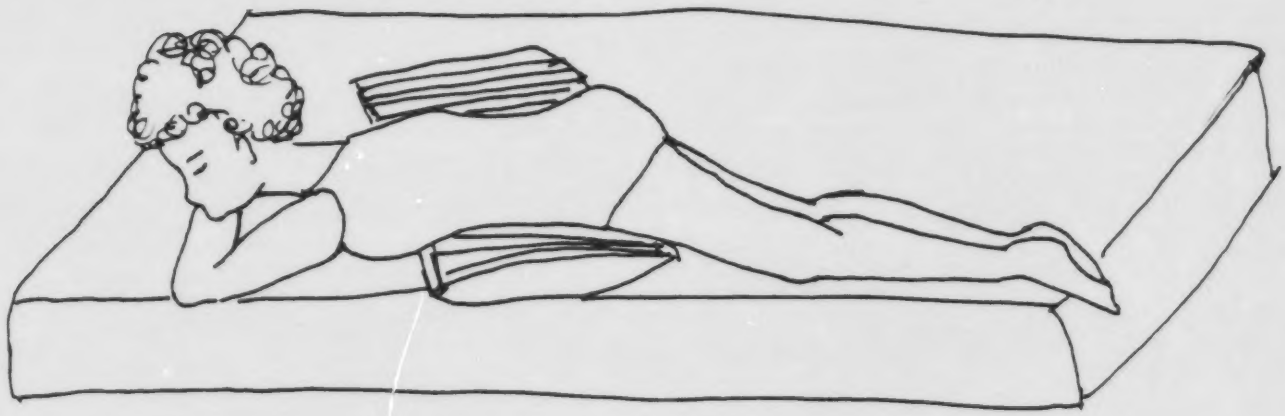
4. Pelvic Tucking - Tighten the lower abdominal muscles as you tuck under your buttocks. This will flatten your lower back and rock your pelvis forward. Now relax your abdomen and buttocks and allow the curvature of your back to return. The movement should be slow and rhythmic. Repeat five times. This exercise can be practiced standing or lying on your back with knees flexed.



When the baby is 4 - 6 weeks old you may discontinue the above exercises to restore abdominal tone and start more strenuous abdominal exercises, such as leg raising (single leg first, then both together, keeping knees straight, and sit-ups (lying flat and slowly raising your upper body to a sitting position). These are too strenuous for the newly-delivered patient, and should not be undertaken until they can be done comfortably.

Lying Prone - Lying on your abdomen for short periods the first few days following delivery helps the uterus return to its normal position. Place your pillow under your hips and rest your head on your arms.

pillow under lower chest and abdomen



Pelvic Floor Restoration - Slowly tighten the rectum and the muscles surrounding the vagina. Then relax slowly and repeat. This exercise will reduce the discomfort in the pelvic area, as it improves the muscle tone of the pelvic floor. It should be practiced several times a day and may be done sitting, standing, or lying down.

WHAT IS LAMAZE?

The educational foundation that prepared childbirth classes such as our PACE classes spring forth from goes back to the 1930's and 1940's. An English doctor, Dr. Grantley Dick-Read in ***Childbirth Without Fear*** introduced his theory on the Fear-Tension-Pain cycle of childbirth.

Dr. Read observed that the uneducated laboring mother entered into this vicious cycle as her labor began and she spiralled upward until she was uncooperative and out of control. Dr. Read introduced childbirth education to these mothers but this alone was insufficient to break the cycle.

In the 1950's Dr. Fernand Lamaze, a French obstetrician added to the work of Dr. Read by introducing techniques to re-condition her responses to the contractions of childbirth. These techniques encompass physical, intellectual and emotional preparation and training. The physical training involves body building, relaxation exercises and introduces various breathing techniques. The intellectual prepartion allows the expectant parents to gain a thorough knowledge of pregnancy, the childbirth process, hospital routines, infant care and care of the mother after childbirth. This education fosters confidence in the expectant mother and enhances her relaxation throughout the pregnancy cycle. The emotional preparation includes utilizing an active labor coach, often the expectant father, to be trained right along with the mother, who can serve as her primary support system during her labor and delivery.

In addition, attitudes and feelings may be "aired and shared" with the other couples who attend the classes.

Collectively, these tecniques are called the psychoprophylactic method which simply refers to using the mind to prevent the discomfort of childbirth.

Our minds can only concentrate on one focus at one time and if that focus during labor is the bodily sensations of the labor, this discomfort will be intensified. If however, we are "conditioned" to respond to the contraction by getting busy with concentration, breathing exercises, relaxation techniques and visual and auditory stimuli, we can successfully reduce the sensations of labor.

As any type of radical change is slow in coming, it was not until the 1960's and well into the '70's that American medical practice slowly began to turn to these techniques as a reliable and routine way of delivering babies. Over the years it has been shown conclusively that these methods have enhanced the physical well-being of the newborn infant as well as the mother. Unanesthetized mothers recuperate more rapidly and are able to greet and care for their infant earlier. Fathers who have been involved throughout the pregnancy, labor and delivery are as much a part of this life experience as the mother. Attachment to the infant will begin from the moment of birth for the father as well as the mother.

However, it is important to keep in perspective that "awake and aware" delivery with the father present is not our primary goal. Our major objective is to improve the physical and emotional health of the mother and child throughout the pregnancy, labor, and delivery, by preparing parents to thoroughly understand and thereby aid in their own care and the care of their infant.

INTRODUCTION TO PACE

The Professional Association for Childbirth Education of Broward County, a non-profit association, was founded in June, 1976, out of a need to promote and maintain high quality childbirth education by professionals in the community. It was formed by a group of registered nurses who had been teaching childbirth education classes for many years.

PACE instructors, having completed an extensive childbirth education course nationally approved by the American Society for Psychoprophylaxis in Obstetrics are certified childbirth educators.

Our community involvment includes providing professional workshops and continuing education for instuctors as well as nursing personnel. PACE has been approved by the Florida State Board of Nursing to provide continuing education credits for registered and licensed practical nurses.

PACE has the full support of the medical community, and many of its health professionals serve in an advisory capacity.

Each childbirth experience is a highly personal one. PACES's main objective is to present accurate childbirth information so that each expectant couple may draw from their learning what they need to make their experience meaningful.

Our prenatal classes consist of eight two-hour classes designed to increase the couple's understanding of pregnancy, childbirth and child care.

Refresher classes are offered for those couples who have had a previous Lamaze birth.

Cesarean classes are offered for couples anticipating a Cesarean birth.

A free Early Pregnancy class is also offered monthly.

Classes are taught continually in many convenient locations.

CEA is ...

a group of parents and professionals who volunteer their time to promote the concepts of family-centered maternity care. The original consumer group serving the community since 1967, CEA of Broward County, a non-profit organization, prepares more than 1000 couples annually.

OUR GOALS

- To give couples sufficient information regarding pregnancy, labor and delivery, so they will have realistic expectations free from myths and fears.
- To make couples aware of the individuality of the childbirth experience, and to give them the tools to work with labor and delivery.
- To enable couples to work together, responding to one another in a supportive way.
- To give couples an understanding of the options available to them, so that they can make informed choices concerning maternity care.

EARLY PREGNANCY CLASSES

Two free classes for those who are newly pregnant and eager to learn all they can about the miracle of life they are experiencing. Class content includes information on fetal development, nutrition, the physical and emotional aspects of pregnancy, body mechanics and conditioning, and concepts of family-centered maternity care. Call office for registration. Offered bi-monthly.

CHILDBIRTH CLASSES

Modified Lamaze course, consisting of six classes 2½ hours each, once a week for six weeks starting after the sixth month of pregnancy. Included in the class is information on stages of labor and delivery, breathing and relaxation techniques, and physical conditioning exercises. Also discussed are hospital procedures, breastfeeding, medications, post partum and family adjustment. Visiting the class are a guest couple and a La Leche Leaque speaker. Prepared childbirth does not imply a painless or drugless childbirth. Accurate class informantion alleviates unreasonable fears and misconceptions with knowledge, confidence and a positive attitude toward childbirth.

ENCORE CLASSES

A four week refresher course available to couples who have had a prepared birth experience.The series reviews the basics of childbirth preparation with emphasis on available options and preparation of older child for the new baby.

C - Caesarean
L - Listen
E - Encourage
C - Counsel
T - Teach

C—LECT CLASSES

A series of 4 weekly classes for those anticipating a Caesarean birth. Content includes information on medical procedures, indications for Caesarean delivery, types of anesthesia, post-operative recovery, marital relationships, a slide presentation of Caesarean birth, exercises, comfort measures, and breastfeeding the Caesarean baby.

BABY CARE WORKSHOP

Offered the second Friday night of every month. Three-hour workshop includes newborn care, diapering, bathing, feeding, illness & more. Included are films or slides and a discussion period. Open to public, $5.00 registration fee. Call office for date & location.

Attire for all classes should be shorts or slacks. Bring 2 bed pillows and a blanket or exercise mat to every class.

CEA classes are taught by certified childbirth educators, who have experienced a prepared childbirth and successfully breastfed their babies.

A variety of current films are offerred once a month at a central location.

Classes are held both day & evening at various hospitals and community centers convenient to every one in Broward County. Please register early!

VOCABULARY

1. Afterbirth - the placenta and membranes which are expelled during the third stage of labor.
2. Afterpains - contractions of the uterus following the third stage of labor as it returns to its prepregnant condition. They can last from several hours to several days. Relax and use deep chest breathing.
3. Amnesia - loss of memory.
4. Amniotic sac - membranes filled with fluid which enclose the baby before birth. Also called the bag of waters.
5. Analgesic - a drug which relieves pain.
6. Anesthesia - absence of all sensation of pain.
7. Areola - the dark area around the nipple.
8. Back labor - contractions which are felt almost entirely in the lower back. It is occasionally related to the position of the baby.
9. Braxton-Hicks contractions - uterine contractions occurring periodically throughout the pregnancy. They do not dilate the cervix.
10. Breech - baby is in bottom first position.
11. Caesarean birth - operative delivery of the baby through an abdominal incision when delivery through the birth canal is not feasible.
12. Cervix - the neck of the uterus which is closed throughout pregnancy and is opened by the labor contractions to allow the baby to enter the birth canal.
13. Colostrum - yellowish fluid secreted by the breast just before and right after birth.
14. Contraction - the tightening and shortening of the uterine muscle during labor.
15. C.P.D. (Cephalo-pelvic-disproportion) - baby's head is too large for pelvic outlet necessitating surgical intervention (i.e. Caesarean section).
16. Crowning - appearance of the presenting part causing bulging of the perineum.
17. Dilation - opening of the cervix from 0 to 10 centimeters.
18. Effacement - thinning of the cervix from 0 to 100%.
19. Episiotomy - surgical incision to enlarge the outlet of the birth canal.
20. Involution - return of the uterus to its prepregnant state.
21. Meconium - dark, tar like substance which fills infant's intestine before birth and is seen in first bowel movements following delivery.
22. Mucous Plug - thick mucus which fills the cervical opening and prevents infection from entering the uterus during pregnancy.

23. Multigravida - one having a second or subsequent pregnancy.

24. Perineum - the area of the pelvic floor between the vaginal opening and the anus.

25. Primigravida - one having the first baby.

26. Show - discharge of mucus from the vagina before or during labor. It may be tinged pink due to rupture of capillaries. (Oten this is called the bloody show.)

27. Transition - the period of labor just before the cervix is completely dilated. It is the shortest and most difficult phase of labor.

28. Umbilical cord - the blood vessels connecting the baby with the placenta.

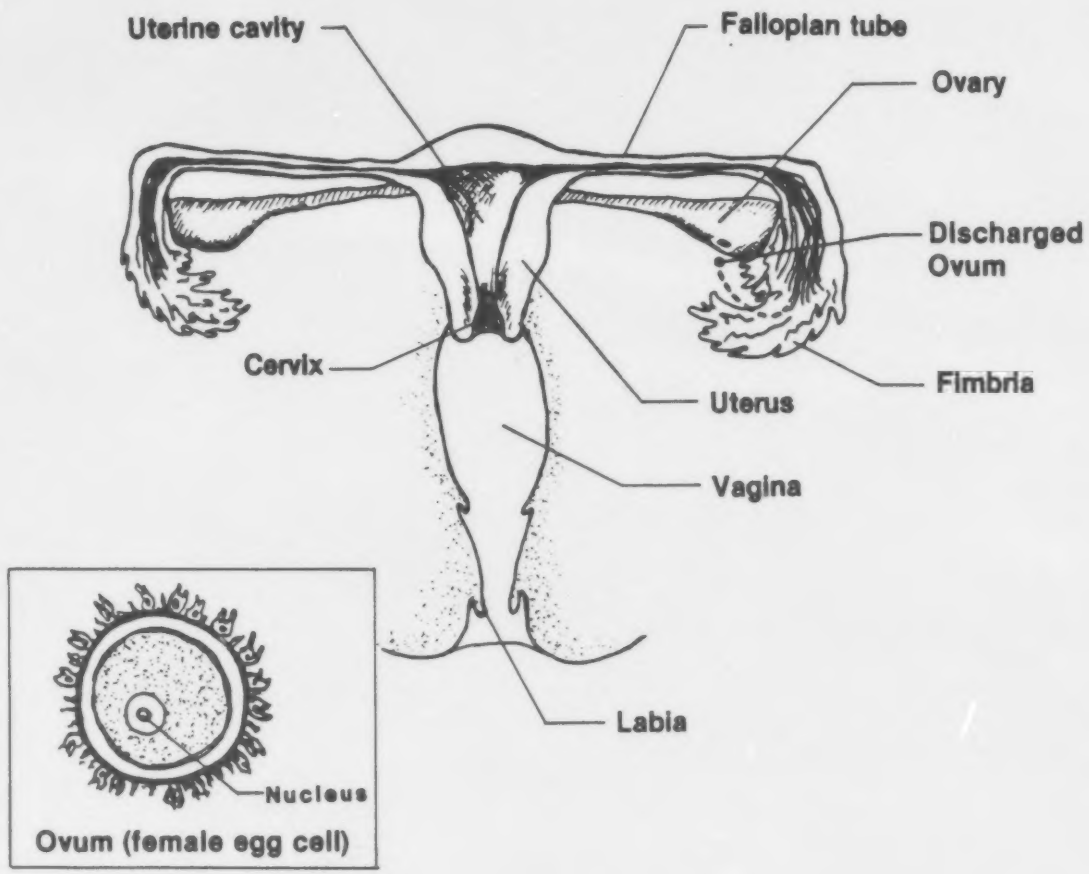
29. Uterus - a hollow muscular organ in which the baby develops.

30. Vagina - the canal extending from the neck of uterus to the vulva through which the baby is born.

31. Vernix Caseosa - the protective cheesy looking substance which covers the skin of the baby.

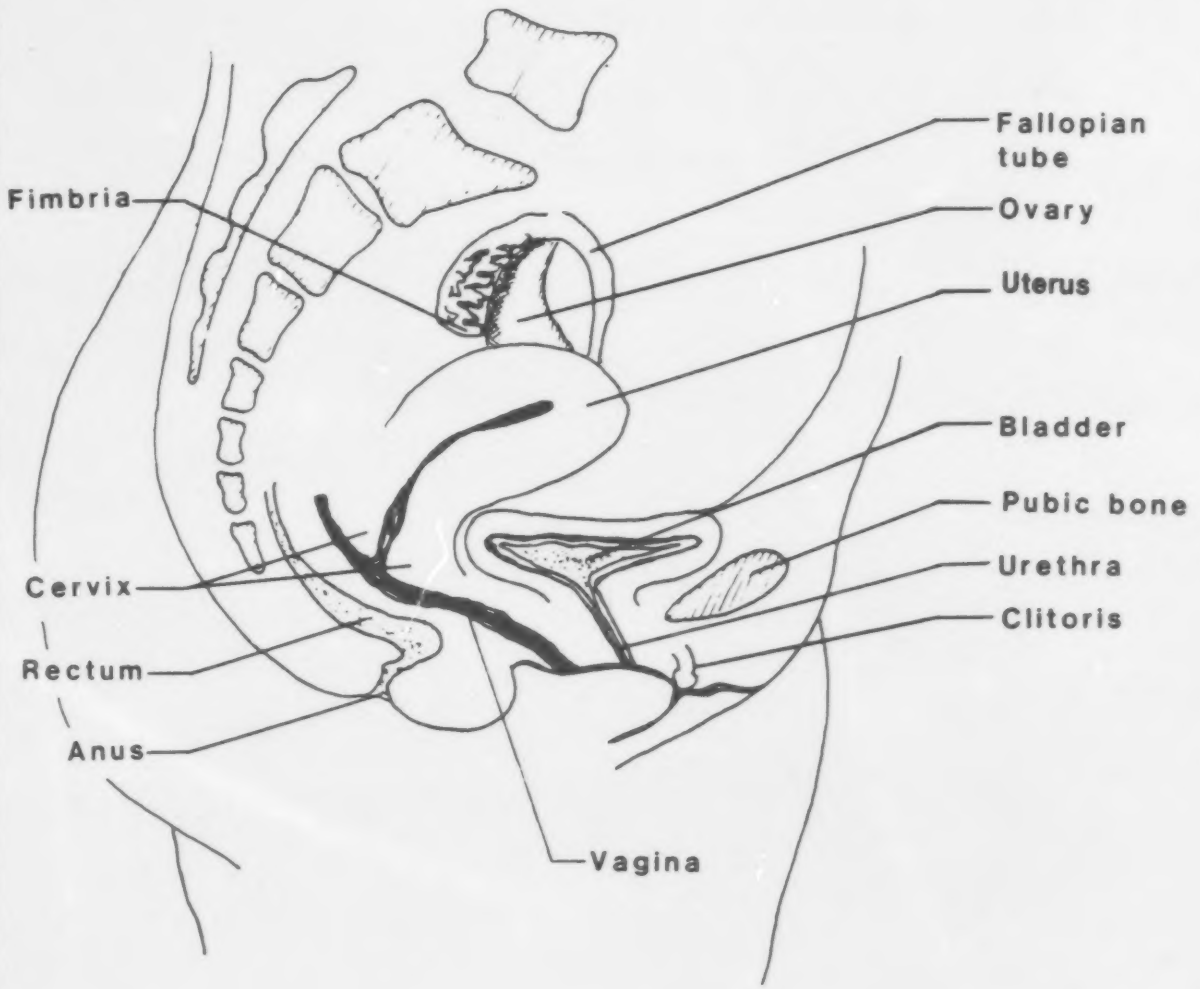
32. Vulva - the externally visible portion of the female genitals.

If motherhood is so natural
why all the instructions?



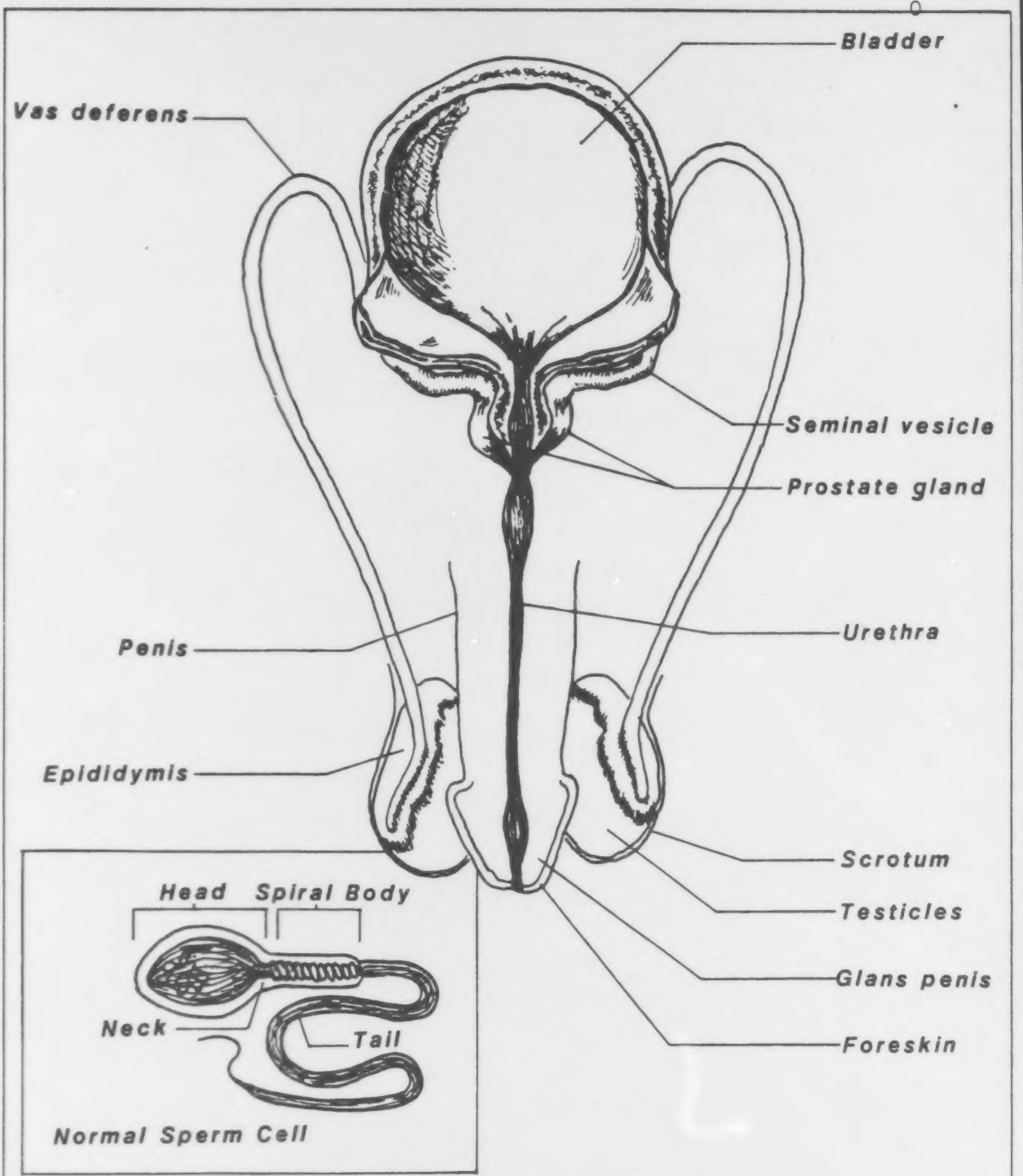
The Female Reproductive System
(Front View)

Permission granted by New Futures, Inc., for reproduction of this material.



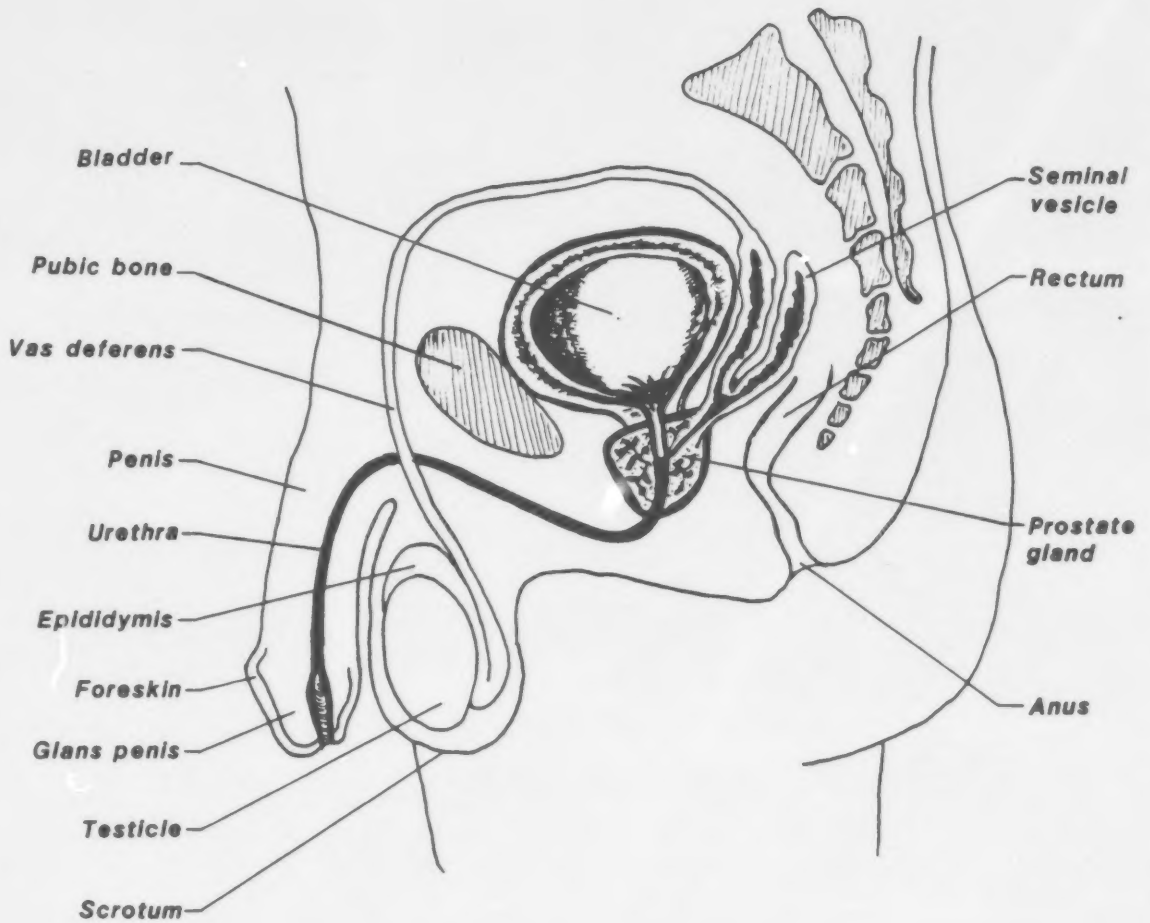
The Female Reproductive System
(Side View)

Permission granted by New Futures, Inc., for reproduction of this material.



The Male Reproductive System
(Front View)

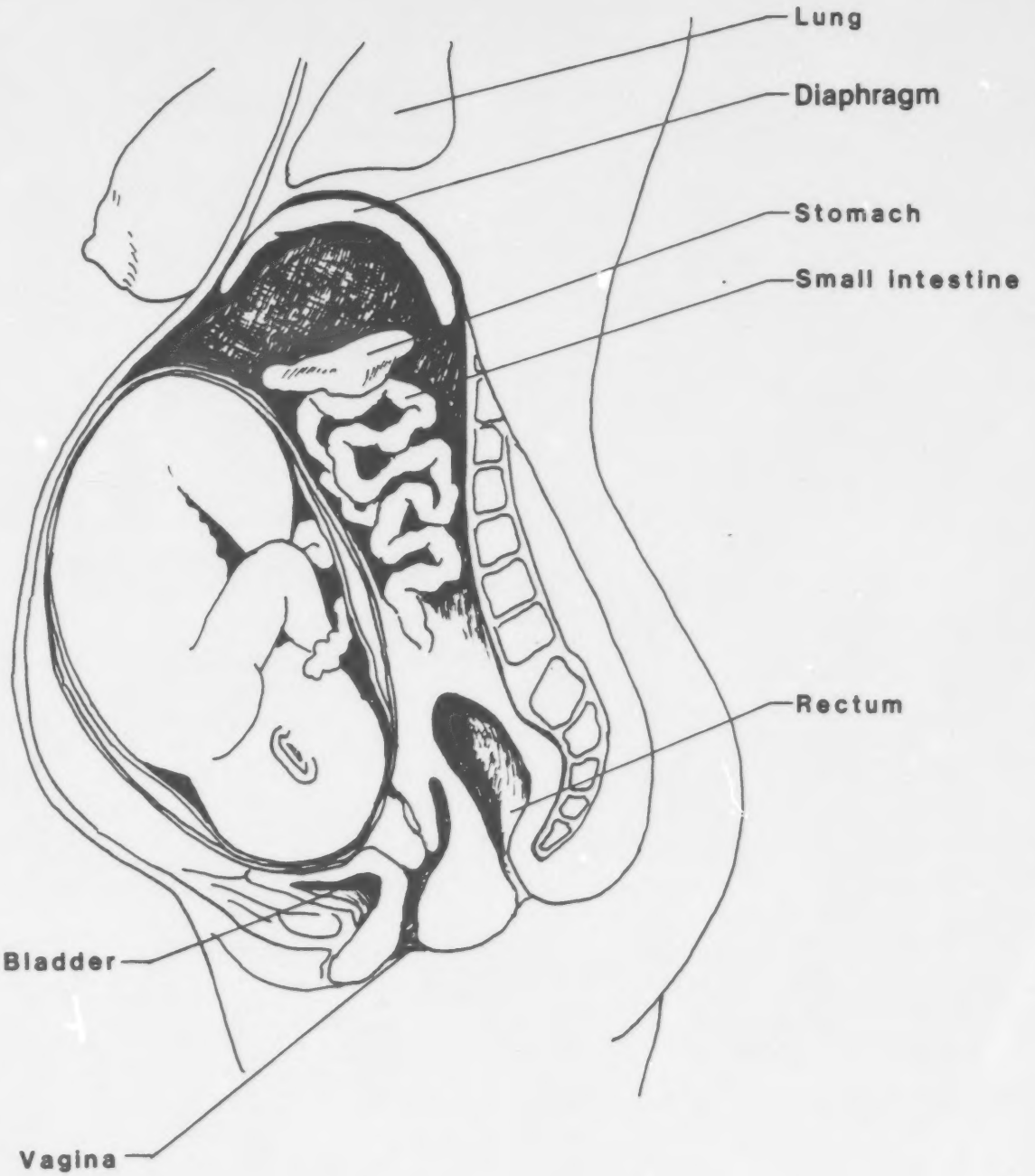
Permission granted by New Futures, Inc.,for reproduction of this material.



The Male Reproductive System
(Side View)

Permission granted by New Futures, Inc., for reproduction of this material.

Relationship of the Developing Baby to the Organs in the Mother's Body

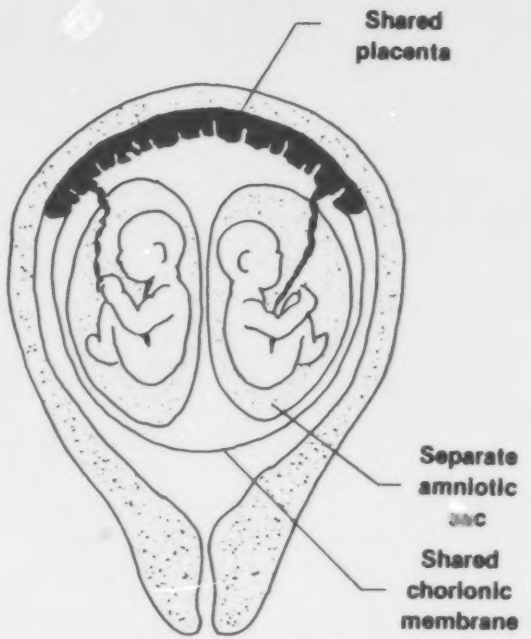


Many of the common complaints of pregnancy are caused by the crowding of the organs by the enlarged uterus. Some of these include: 1) constipation, 2) urinary frequency, 3) heartburn, and 4) shortness of breath.

Permission granted by New Futures, Inc., for reproduction of this material.

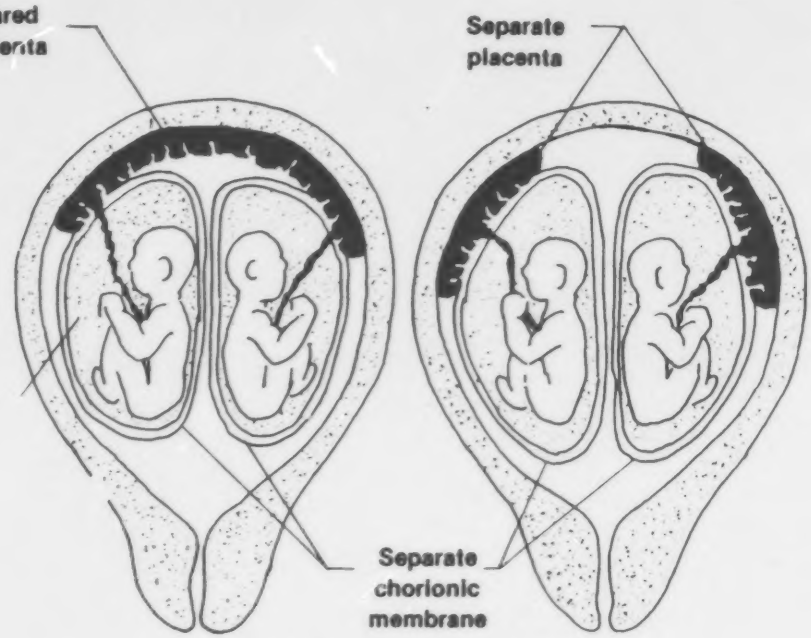
Multiple Births

"Multiple births" is a term that means having more than one baby at the time of delivery. Twins are the most common form of multiple births, occurring 1 in 90 births. Triplets are born 1 in 8,000 births. Quadruplets are born 1 in every 500,000 births. There are two types of twins, identical and fraternal.



Identical Twins

Identical twins look alike and are always the same sex. They develop from one egg cell that was fertilized by one sperm cell. They share the same placenta and chorionic sac. Each twin has his/her own umbilical cord and amniotic sac.



Fraternal Twins

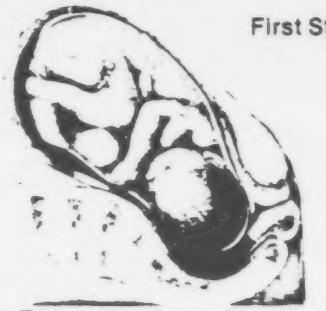
Fraternal twins do not look any more alike than any brothers and sisters because they develop from two individual egg cells that were fertilized by two different sperm cells. They may or may not be the same sex. Each twin has his/her own cord, chorionic and amniotic sacs, and placenta. Sometimes the placentas grow together and appear to be one.

Permission granted by New Futures, Inc., for reproduction of this material.

Mechanism of Normal Labor

To increase your knowledge of the labor and delivery process, we have developed the following chart which describes the mechanics of normal labor. The diagrams show the movement of the baby through the mother's pelvis during the labor and delivery process. The baby goes through a series of twisting and curving motions as his head adjusts itself to the size and shape of the mother's pelvis.

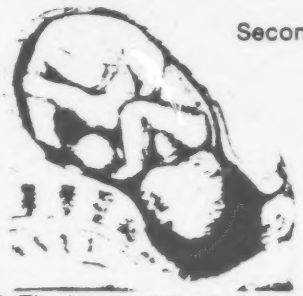
First Stage



1. Engagement
2. Descent
3. Flexion

1. Engagement usually occurs before labor begins when the baby's head drops into the pelvis.
2. The head descends lower into the pelvis during the first stage of labor.
3. The chin touches the baby's chest as his head flexes during descent.

Second Stage



4. Internal Rotation

4. The head rotates to bring its longest diameter toward the longest diameter of the pelvic outlet.

5. Extension Beginning

5. The pressure from contractions causes the head to extend from its flexed position upward toward the vaginal opening.

6. Extension Complete (Crowning)

6. When extension is completed, the crown of the baby's head can be seen at the vaginal opening.

7. External Rotation (Restitution)

7. The head slips out of the vagina and turns to the side.

8. External Rotation (Shoulder Rotation)

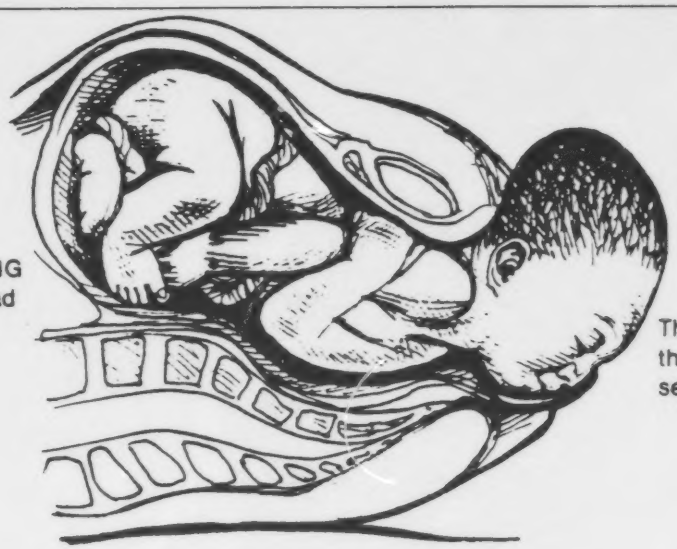
8. The shoulders, which are now turned to the side, can be delivered one at a time: one from under the symphysis pubis (pubic bone) and one up and over the perineum.

9. Expulsion

9. The rest of the baby's body is quickly delivered, thus ending the second stage of labor.

Pictures from *Mechanism of Normal Labor* (Clinical Education Aid No. 13), Ross Laboratories, Columbus, Ohio.

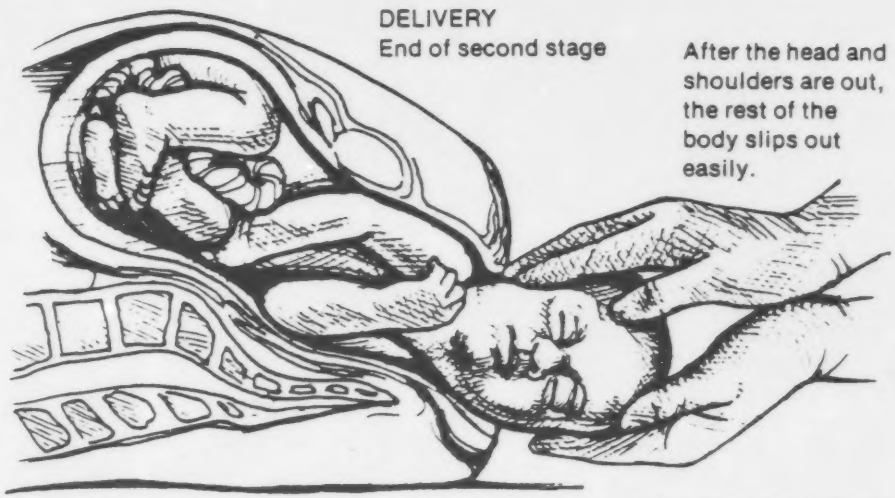
Permission granted by New Futures, Inc., for reproduction of this material.



CROWNING
Top of head

The crown of the head is seen.

DELIVERY
End of second stage

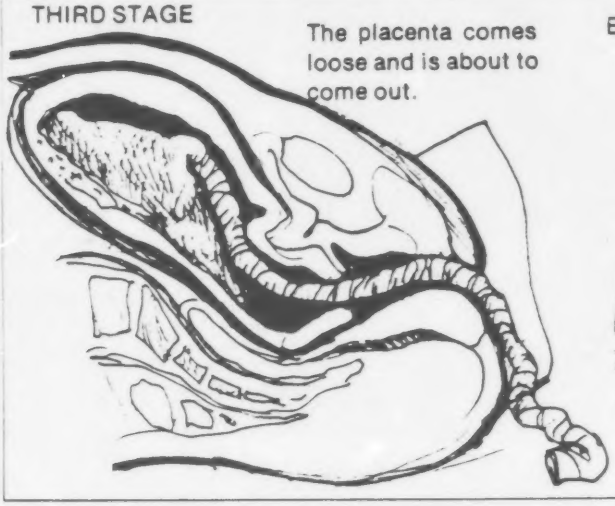


After the head and shoulders are out, the rest of the body slips out easily.

The third stage of labor is the delivery of the placenta (afterbirth). It begins as soon as the baby is born and lasts until the placenta separates from the wall of the uterus and comes out.

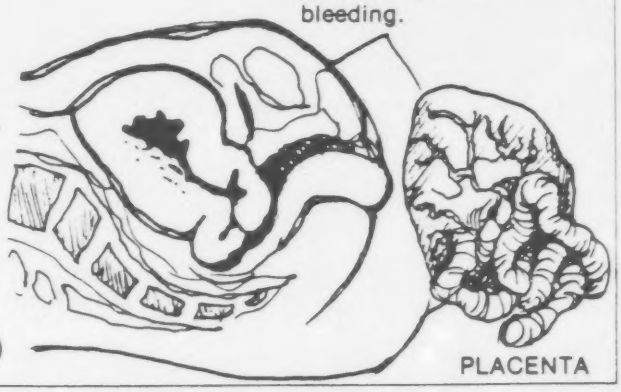
THIRD STAGE

The placenta comes loose and is about to come out.



END OF THE THIRD STAGE

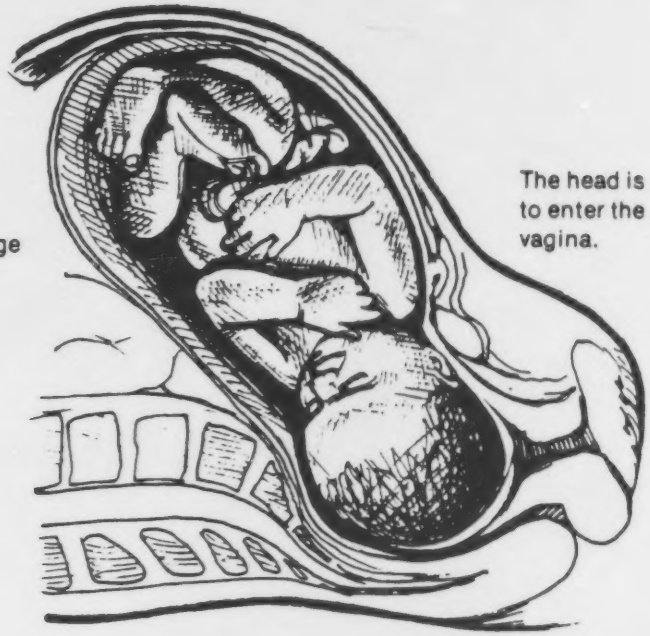
The uterus tightens quickly to prevent bleeding.



PLACENTA

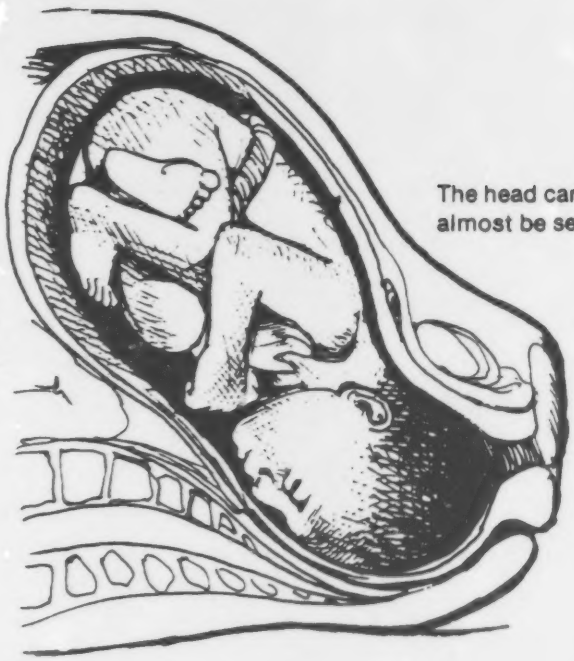
The second stage of labor is the delivery stage. It begins when your cervix is completely opened up and ends when the baby is born. You will be able to help by pushing to bring the baby down and out. The baby *does not* push himself out! You will go to the delivery room when the top (crown) of his head can be seen at the opening of your vagina.

TRANSITION
End of the first stage



The head is ready to enter the vagina.

BEFORE CROWNING
Middle of second stage



The head can almost be seen.

EMERGENCY DELIVERY

(Or what to do if you don't make it to the hospital)

1. DON'T PANIC!!!!

2. In such cases it is usually a normal, easy and safe delivery.
   a. Contractions will follow a normal but quicker pattern.

3. If you are home call the doctor; if you are on the way to the hospital pull over and stop.

4. Make mother as comfortable as possible.
   a. Use the comfort measures and breathing techniques used in class.
   b. Be reassuring.

5. After the head begins to crown, pant and blow, instead of pushing, through the rest of the contractions until the baby is born.
   a. The baby will slide out slowly. (Don't pull on the baby.)
   b. May prevent tearing.

6. Do not touch the pelvic floor, but catch the baby.

7. Hold the baby by his feet to clear air passages of mucus and water. Be careful, he's slippery.

8. Don't spank him; snap the bottom of his feet if he doesn't cry on his own.

9. Don't pull on the cord.
   a. Let the placenta come on it's own. (It's okay to push a little.)

10. Put the baby to your breast immediately, (if the cord will reach; if not, wait until the placenta is expelled) even if not planning to breastfeed.
    a. This will comfort the baby.
    b. It will help detach the placenta.
    c. It will lessen the chance of hemorrhage.

11. Don't tie or cut the cord.

12. Wrap the baby, cord and placenta in the cleanest thing available.
    a. Keep mother and baby warm.

13. Follow the doctor's orders or proceed to the nearest emergency room.

BREASTFEEDING

Breastfeeding is a natural womanly function. Be confident that you will be able to nurse your baby if you desire providing you gain the knowledge and understanding necessary.

Breastmilk is the perfect food for the human infant. Its ideal composition makes it easy for the baby to digest, and in itself never causes an allergic reaction to the baby. Always available to the baby and at the correct temperature, there never needs to be any fear of it "spoiling". Breastfed babies are less susceptible to communicable diseases as they receive immune factors from the mother both in the colostrum (the earliest breast secretions) and in the milk itself. Breastfeeding also provides the baby with a psychological as well as physical closeness to his mother, thus helping him to feel love through physical contact with her. Nursing gives the baby a closeness with his mother that helps meet his need for security.

Advantages to Mother

Breastfeeding helps the mother's uterus return to normal quickly. When the baby nurses, two hormones (oxytocin and prolactin) are released by the pituitary gland into the mother's bloodstream. Oxytocin causes the uterus to contract and lessens blood loss after birth. Oxytocin is also responsible for the "let-down" reflex which pushes the milk into the ducts of the breast so that the baby can suck it out. Prolactin causes the mother to relax and also enhances motherly feelings as well as sustaining milk production.

Because there is nothing to prepare, wash or sterilize, breastfeeding saves time. It also saves money as the healthy, full-term baby usually needs no other food or supplement until the second half of the first year of life.

Traveling with a breastfed baby is easy as you need only to take diapers and clothing in sufficient quantity to last the time you are away from home.

Nipple Preparation

During pregnancy your regular bath is all the cleansing your nipples will require. Go easy on the soap as it tends to be drying. Toward the end of pregnancy it is a good idea to spend some time conditioning the nipples. You can rub the nipples gently with a terrycloth towel or pull them out firmly with your fingers several times. Some mothers use cold cream or baby oil as a lubricant. These routines should be done only until it is slightly uncomfortable and not to the point of pain. It may be helpful to go without a bra for part of the day or to wear a nursing bra with the flap open. This exposes the nipple to air and gentle friction from your outer clothing.

Getting Started

Early frequent nursing with no supplements encourages a gradual coming in of the milk and will help to prevent engorgement.

Colostrum is the yellowish substance secreted from the breast during the latter part of pregnancy and before the milk comes in. It is present in the milk for about ten days. Colostrum is tailored to the newborn's digestive system and has a laxative effect. Colostrum is higher in immune factors than the milk itself, and helps get the baby off to a good start.

The hospital may have some routine for cleansing the nipples. If possible avoid soap, alcohol or moist towelettes as these tend to be drying. At home many mothers find that hand washing is all the cleansing routine necessary.

If the baby is sleeping, sometimes unwrapping him will awaken him enough to nurse. Just joggle the baby gently and place his cheek against your breast. If he doesn't wake up don't force him to nurse, especially if the baby is being brought to you every three hours.

AFTER PREPARED CHILDBIRTH, PREPARED MOTHERING

WHY YOU SHOULD CONSIDER BREASTFEEDING YOUR BABY

We feel that it is important for you to plan to attend a series of La Leche League meetings, even if you are confident about your ability to breastfeed.

La Leche League is a non-profit, non-sectarian group of specially trained mothers, all of whom have successfully breastfed a child of their own. The League, formed informally in Chicago, in 1956, when a group of nursing mothers saw the desirability of mutually exchanging know-how and solutions to problems common to nursing mothers, has grown into a service organization with more than 1,800 chapters in 32 foreign countries and the United States.

La Leche League classes are free and offer you the following services:

1. A series of four monthly meetings on these subjects:
   A. The advantages of breastfeeding (to mother, father, and the baby)
   B. The art of breastfeeding and overcoming difficulties
   C. The birth of the baby and the baby in relation to the rest of the family
   D. Nutrition (for the expectant mother, the nursing mother, the baby) and weaning (how to and when to)

2. Counselling twenty-four hours a day by experienced, trained and approved League Leaders who will help you to reach your nursing goals.

3. A manual, "The Womanly Art of Breastfeeding", available at cost, with detailed helpful 'how to' information

4. A free Lending Library of books and pamphlets on breastfeeding and other aspects of parenthood.

If you are considering nursing your baby, you will want to attend a complete four-month (one night a month) series of La Leche League meetings. If your baby will come before you can complete the series, try to come to as many meetings as you are able. After the baby comes, you will want to finish the series, or even attend a second time. There is so much valuable, practical information to be gained from these friendly, informal meetings. One last thing - League series meetings are open to mothers and their babies only. Of course, fathers and the rest of the family are welcome at all other La Leche League events.

PHYSICAL BENEFITS.

a. GET YOU BACK INTO SHAPE. "Putting the newborn baby to the breast as soon as possible after birth helps to control blood loss. The baby's sucking causes the uterus to contract, which helps prevent hemorrhage after delivery. Also, continued nursing will help you to get back into shape again internally." Womanly Art of Breastfeeding

b. ANEMIA IN MOTHERS. Breastfeeding, by delaying the reestablishment of menses, aids in conservation and rebuilding of maternal iron stores.

c. "HAPPY" HORMONES. Prolactin and oxytocin aid in the prevention of 'postpartum blues' by giving the mother an inclination to be motherly. Experienced nursing mothers often experience a flooding sense of peace and joy as their milk lets down. Nursing your Baby by Karen Pryor

BEST FOR FAMILY

1. BENEFITS. "Discounting the soaring cost and shortages we've been so keenly aware of, the benefits of Human Milk far outway economy. This unique gift offers a bridge of tolerance, understanding, patience, and love which developes between mother and baby and is carried over in our relationships with all people." Susan Saint James

2. ECONOMY. Breastfeeding, despite some arguments to the contrary, costs but a fraction of artificial feeding. Another advantage for the father is that there will probably be fewer doctor bills because the nursing baby is rarely ill.

3. SUPPORTIVE HUSBAND. A husband's attitude and support are crucial to the success of the nursing relationship. "The best preparation a nursing mother can have is a man who loves her." Sheila Kitzinger

4. LESS CRYING. It is rare for the nursing baby to have colic or to cry a great deal. At the 2:00 A.M. feeding, the baby does not have to wait for the bottle to heat.

5. SEX EDUCATION. Breastfeeding offers a natural opportunity to introduce sex education to older children within a family setting.

6. CONSERVATION. Breastfeeding is the natural way to nourish your baby, no messy bottles, mixing, or throw away containers.

7. TRAVELING. Family trips are much easier with a nursing baby. The younger, the better. All you need are diapers and clothes. You never need to worry about a change in water. Milk is always ready and available.

MORE IMPORTANT FACTS FOR YOU TO KNOW

I. The size and shape of a mother's breast have nothing to do with her ability to produce milk. All women have the same number of milk glands. Size is determined by fatty tissue.

BEST COPY AVAILABLE

THE FIRST FEW WEEKS AT HOME

A Baby Needs

1. A place to sleep
2. Clothing
3. Equipment for feeding
4. Equipment for bathing

1. For Sleeping:

FLANNELETTE COVERED WATERPROOF SHEETING (2 or 3) - put this over mattress for protection

SHEETS (3 or 4)

SQUARES OF WATERPROOF SHEETING (3 or 4) - to put under baby so wet diapers and messes won't dirty sheet; will save on washing

RECEIVING BLANKETS (3 or 4) - to use in cold weather or as a towel when bathing

BLANKET BAG or "SLEEPING BAG" - for sleeping in cold weather, won't have to worry about blanket slipping off

2. For Dressing

COTTON KNIT NIGHTGOWNS (3 or 4) - long ones best; can also use stretch outfits or diaper and T-shirt

COTTON KNIT SHIRTS - short sleeves; large arm and head openings; no tapes or buttons

SWEATERS or SACKS (2 or 3) - "stretch outfits"; nylon or orlon easiest to wash; a few easy to open buttons in front

CAP (one)

DIAPERS (3 to 6 dozen) - prefolded ones good; diaper service about $15.00 a month; check price of disposable diapers

PLASTIC PANTS (2 or 3) - don't put in dryer

BOOTIES

3. For Eating

NURSING BOTTLES WITH CAPS (6 to 8) - 8-ounce size; get boilable, plastic ones - won't break

NIPPLES - get one for each bottle and one or two spares; silicone ones last longer

A BOTTLE and NIPPLE BRUSH

FORMULA - ordered by doctor

4. For Bathing

A PLASTIC TUB OR DISHPAN - can use kitchen sink; put towel on bottom to stop slipping

CAKE OF MILD SOAP

WASH CLOTH (4 to 6) - can also use to clean baby when changing diaper

Other Equipment

Buy large size - cheaper

BABY POWDER

VASELINE

DIAPER PINS (safety ones)

RECTAL THERMOMETER

DESITIN - for diaper rash

BABY LOTION

FORMULA - BABY FOOD

No Q-Tips! Dangerous!

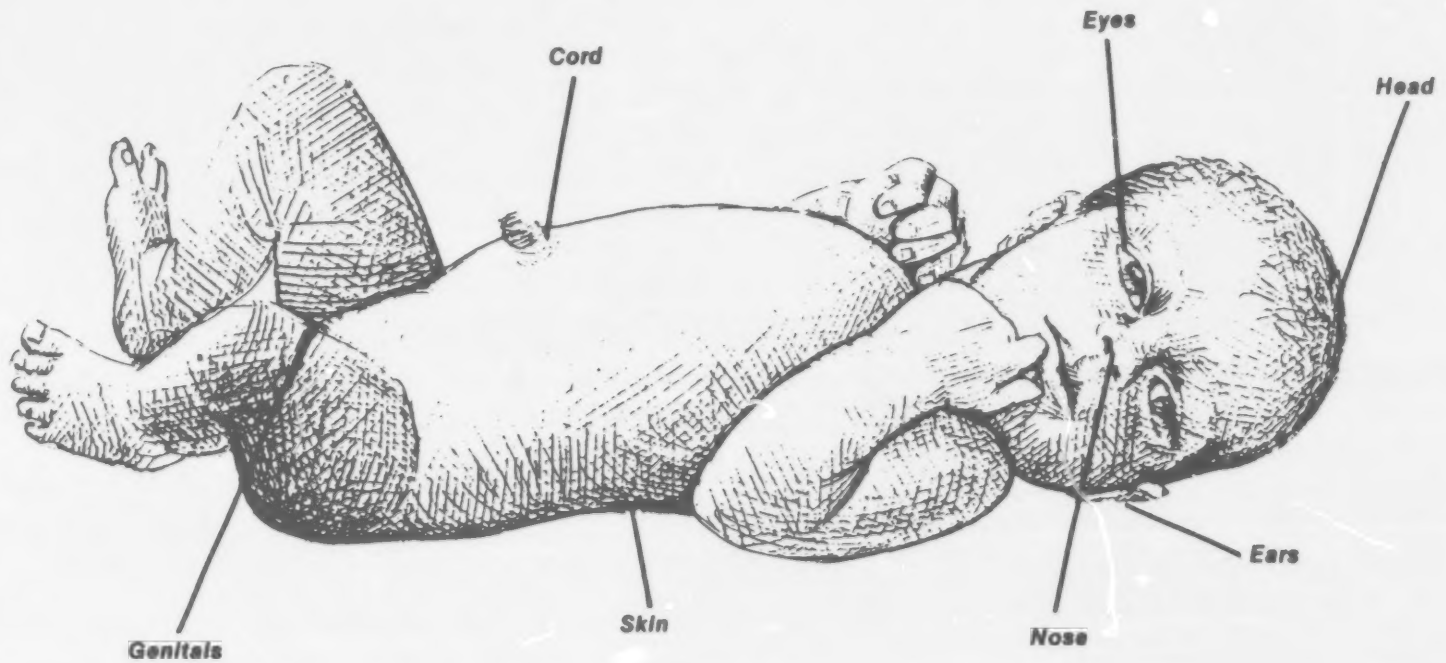
SHOPPING LIST

Item	No. Needed	Price of Each
Waterproof sheeting - flannelette	2 - 3	
Sheets	3 - 4	
Squares of sheeting	3 - 4	
Receiving blankets	3 - 4	
Sleeping sack or bag	3 - 4	
Cotton knit night gown	3 - 4	
Cotton T-shirts (undershirts)	3 - 4	
Sweaters or sacks (stretch outfit)	2 - 3	
Cap	1	
Diapers - cotton check price of disposable	3-6 doz.	
Nursing bottles with caps - 8 oz. size	8 - 12	
Nipples	12 - 14	
Bottle and nipple brush	1	
Formula ready to use concentrated		
Plastic tub/dishpan		
Washcloths		
Baby powder Vaseline Safety pins Rectal thermometer Desitin Baby lotion		
Crib Infant seat High chair		
Baby food		
Plastic pants		

Explain how each of the things in this picture may be dangerous to a baby.

Permission granted by New Futures, Inc., for the reproduction of this material.

Describe the care that is given to each of the body parts listed below:



Permission granted by New Futures, Inc., for the reproduction of this material.

SAMPLE

ACCIDENT PREVENTION MEASURES*

Age	Characteristics	Accident Hazards	Measures for Prevention
Birth to 4 Mos.	Eats, sleeps, cries	Bath-Scalding	Check bath water with elbow. Keep 1 hand on baby.
	Rolls off flat surfaces Wiggles	Falls	Never turn back on baby who is on table or bed.
		Toys	Select toys that are too large to swallow, too tough to break with no sharp points or edges.
		Sharp objects	Keep pins and other sharp objects out of baby's reach.
		Smothering	Filmy plastics, harnesses, zippered bags, and pillows can smother or strangle. A firm mattress and loose covering for baby are safest. Babies of this age need complete protection.
4-12 Mos.	Grasps and moves more. Puts objects in his mouth.	Play areas	Keep baby in a safe place near attendant. The floor, full-sized bed, and yard are unsafe without supervision.
		Bath	Check temperature of bath water with elbow. Keep baby out of reach of faucets. Don't leave him alone in bath for any reason.
		Toys	Large beads on strong cord and unbreakable, rounded toys of smooth wood or plastic are safe.
		Small Objects	Keep buttons, beads, and other small objects from baby's reach. Children of this age still need full-time protection.

*_Day Care—Health Services_ A Guide For Project Directors and Health Personnel, U. S. Department of Health, Education and Welfare; Office of Child Development; Superintendent of Documents; United States Government Printing Office, Washington, D. C.; Stock No. 1791-0162.

Age	Characteristics	Accident Hazards	Measures for Prevention
4-12 Mos. (Cont'd.)		Falls	Don't turn your back on him when he is on an elevated surface.
		Burns	Place guards around registers and floor furnaces. Keep hot liquids, hot foods, and electric cords on irons, toasters and coffee pots out of baby's reach. Use sturdy and round-edged furniture. Avoid hot steam vaporizers.
1-2 Yrs.	Investigates, climbs, opens doors and drawers; takes things apart; likes to play	Gates, windows, doors	Keep doors leading to stairways, driveways and storage areas securely fastened. Put gates on stairways and porches. Keep screens locked or nailed.
		Play areas	Fence the play yard. Provide sturdy toys with no small removable parts and of unbreakable material.
		Water	Never leave child alone in tub, wading pool, or around open or frozen water.
		Poisons	Store all medicines and poisons in locked cabinet. Store cosmetics and household products, especially caustics, out of reach of child. Store kerosene and gasoline in metal cans and out of reach of children.
		Burns	Provide guards for wall heaters, registers and floor furnaces. Never leave children alone in house.
			Close supervision is needed to protect child from accidents.
2-3 Yrs.	Fascinated by fire. Moves about constantly. Tries to do things alone. Imitates. Runs and is lightning fast. Is impatient with restraint.	Traffic	Keep child away from street and driveway with strong fence and firm discipline.
		Water	Even shallow wading pools are unsafe unless carefully supervised.
		Toys	Large sturdy toys without sharp edges or small removable parts are safest.

Age	Characteristics	Accident Hazards	Measures for Prevention
2-3 Yrs. (Cont'd.)		Burns	Keep matches and cigarette lighters out of reach of children. Teach children the danger of open flames.
		Dangerous objects	Lock up medicine and household and garden poisons. Store dangerous tools, firearms, and garden equipment in a safe place out of reach of children. Teach safe ways of handling appropriate tools and kitchen equipment.
		Playmates	Accidents are more frequent when playmates are older—the 2 year old may be easily hurt by bats, hard balls, bicycles and rough play.
3-6 Yrs.	Explores the neighborhood, climbs, rides tricycles. Likes and plays rough games. Frequently out of sight of adults.	Tools and equipment	Store in a safe place, out of reach and locked. Teach safe use of tools and kitchen equipment.
		Poisons and burns	Keep medicines and household products and matches locked up.
		Falls and injuries	Check the play area for attractive hazards such as old refrigerators, deep holes, trash heaps, construction, and rickety buildings.
		Drowning	Teach the danger of water and start swimming instruction.
		Traffic	Let him learn rules and dangers of traffic. He must learn instant obedience where traffic is concerned.
6-12 Yrs.	Away from home many hours a week. Participates in active sports, is part of a group and will "try anything once." In traffic on foot and bicycle. Teaching must gradually replace supervision.	Traffic	Drive safely as an example. Use safety belts. Teach pedestrian and bicycle safety rules. Don't allow play in the streets or alleys.
		Firearms	Store safely, handle carefully, teach proper use.
		Sports	Provide instruction, safe space and equipment, supervision of any competition.
		Drowning	Teach swimming and boating safety.

Learning Experiences of the Infant - Zero to Twelve Months

SKILLS AND CHARACTERISTICS	ACTIVITIES HH
Eye focusing and coordination	Hang a colorful mobile on the crib and place colorful pictures in the room. Move a rattle or toy slowly in front of his face so his eyes will follow the toy.
Eye-hand coordination	Let him grab for an object (rattle, blocks, plastic containers) in your hand and let him grasp it, bang it, and shake it. Have different shaped objects such as blocks and containers for him to pick up and hold. He will probably like to put them in his mouth, so be sure they are clean and too large to swallow. Provide objects for placing into a larger container.
Eye-hand hearing coordination	Shake a rattle behind the baby's head. Let him turn and grab the rattle.
Awareness of different textures	Offer the child toys which vary in texture (fuzzy, hard, soft). Talk to him about how they feel.
Self-awareness	Use safe mirrors for the child to look at himself.
Grabbing and pulling	Attach a toy to a string so that the child can pull it across the floor, table, bed,
Reasoning development - hide and seek	Play hide and seek with the baby. Cover his face with your hands. Hide a toy partially by a blanket and let the child recover it. Hide a toy completely with a blanket for him to recover. In this way he learns that objects which are out of sight still exist. Put a toy in a container with a top and let him find it.
Muscle coordination	Provide many opportunities for the baby to be on the floor. Encourage him to stretch, turn over, creep, crawl, pull up. Roll ball and let the baby crawl to it.
Interest in sounds and words	Talk to the baby. Point out his toes, nose, eyes, ears, arms, etc. Say "up you go" "down you go". "The ball is over there". Talk about pictures he looks at.

Reprinted from: Children, Children, Children
The Infant - North Carolina
The Governor's Advocacy Council on Children and Youth
The Office of Child Day Care Licensing
The Office of Child Development

BEST COPY AVAILABLE

SKILLS AND CHARACTERISTICS	ACTIVITIES
Curious about himself	Encourage free play with safe mirrors. Stand or sit with child before a mirror. Talk with him about his reflection. Encourage him to make movements before the mirror.
Ability to recognize objects, animals, people from a picture or toy reproduction	Provide a rubber set of farm animals for free play. Talk about the animal's name, the sound it makes, its color or other characteristics. Look at simple picture books. Let the child point to objects, animals, community helpers as you name them. Talk about the pictures.
Is very active; enjoys running, climbing and throwing	Provide many opportunities for free active play outdoors and inside. Provide free play with climbing equipment such as a wooden rocking boat which can be overturned to make steps for climbing. Encourage climbing on other small safe climbing equipment. Encourage free play with small balls and bean bags. Child can throw ball to an adult or at an object.
Ability to manipulate objects with his hands and fingers	Encourage free play with small blocks; large, hollow blocks; containers and cubes which can be stacked. Encourage free play with large plastic nuts and bolts. (Be sure the items are easy to manipulate). Encourage the child to place small blocks, cubes, and other small items into a container. Provide containers with loose fitting lids. Encourage the child to open and close them.
Can understand some basic concepts, i.e., cause and effect, textures, size	Talk about size of objects. Say, "this is a big ball". "this block is smaller than that block". Talk about textures of objects the child feels. Say, "the rock is hard". "the blanket is soft". Talk about cause and effect relationships. Say, "if you turn over the cup, the juice will spill", or "if you stand in the rain, you will get wet".

Reprinted from: Children, Children, Children
The one year old - North Carolina

BEST COPY AVAILABLE

AGES AND CHARACTERISTIC FEEDING BEHAVIOR (One to Five Years)

Age	Appetite	Refusals/preferences	Self-help
1 year	usually good for all meals breakfast may be poor meal	may refuse milk from bottle and may also refuse milk from a cup preference for foods are becoming well-defined he may prefer one kind of cereal, vegetable, fruit, etc. over another	may use finger feedi for part of meal a few boys may refuse a help may want to stand and eat
18 months	may be decreasing noon meal usually the best	not clearly defined - fluctuates	enjoy feeding self and may do so for all three meals mother may need to fill the spoon child will hand empty dish to caregiver when he is finished
2 years	fair to moderate good noon meal usually best	children are "picky" eaters can name foods and state verbally his likes and dislikes prefers whole pieces of separate foods, dislikes pureed foods or several foods mixed together goes on food jags and may have preference in color, taste, form or consistency	some can feed themselves and do not want help may not want anyone near when he is eating others need help two extreme groups "spotless" to "messy"
2½ years	fluctuates between good and very poor usually eats one good meal- noon or evening may eat better between meals	more defined than 2 years favored are butter, fruit and meat and will feed himself refuses green vegetables will eat some foods if fed	may feed himself entire meal or he may need help in completing likes repetition of food, dishes and arrangement of dishes

BEST COPY AVAILABLE

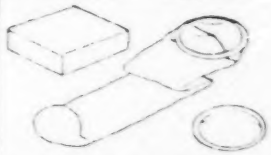
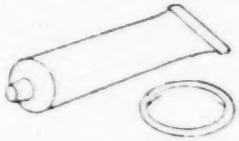
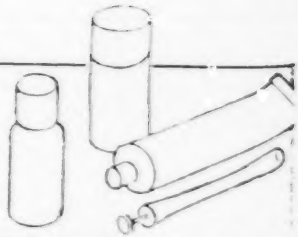
Ages and characteristic feeding behavior from one year to five years

Age	Appetite	Refusals/preferences	Self-help
3 years	fairly good and less variable than before breakfast and supper may be best milk intake increasing	less prominent than before likes meats, fruits, milk, desserts and sweets accept vegetables likes chewy foods may ask for special foods he likes as meal is being prepared	can feed himself and can eat well demands for attention may be excessive
4 years	fair drinks milk rapidly and well	food jags - food strikes may indicate definite preference or dislike for a food	can help plan meals, helps set table, may dawdle but doesn't need to be fed talking usually interf usually has to interru the meal to go to the bathroom much leaving of the ta
5 years	usually good though it varies from meal to meal breakfast is often poorest meal	definite refusals such as casseroles, gravies, puddings and cooked root vegetables. Prefers- meat, potatoes, fruit, milk and raw vegetables	feeds himself but is slow may need help toward end of meal or with certain foods beginning to use a kni for spreading food may request to eat early in the kitchen talking may interfere with his eating

Adapted from: Child Care and Development
Louise Ames

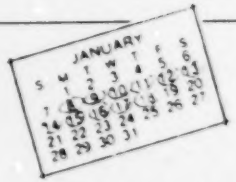
BEST COPY AVAILABLE

METHODS OF CONTRACEPTION

Method	 Condom	 Diaphragm	 Foam, cream, or jelly
How it works	Prevents sperm cells from reaching egg cells	Prevents sperm cells from reaching egg cells	Destroys sperm cells
How well it works	About 97% effective when used correctly Works best when used with contraceptive foam, cream, or jelly	About 95% effective when used correctly with contraceptive cream or jelly	Not very effective when used alone Works best in combination with condom or diaphragm
Comments	No prescription needed Can be bought in drugstores Not expensive Gives some protection against VD Must be used carefully—may break or slip	Prescription needed Must be fitted by a doctor Must be put in place before intercourse	No prescription needed Can be bought in drugstores Must be used just before intercourse

BEST COPY AVAILABLE

MM

Method	IUD	"The Pill"	 Rhythm method	Sterilization
How it works	Exactly how it works not known May prevent fertilized egg cells from attaching to lining of uterus	Hormones in the pill stop release of egg cells from ovaries	Intercourse is avoided during part of menstrual cycle when egg cells are likely to be in Fallopian tubes	In men: Surgical operation cuts or closes sperm ducts and prevents sperm cells from leaving body In women: Surgical operation cuts or closes Fallopian tubes and prevents egg cells from reaching uterus
How well it works	About 97% effective if it is put in place properly and if it stays in place	About 99% effective when used correctly	Not as effective as other methods	Just about 100% effective
Comments	Prescription needed Must be put in place by a doctor May cause cramps or heavy menstrual flow May come out without being noticed	Prescription needed Must be taken on a regular schedule and exactly as prescribed May cause health problems	No prescription needed Special thermometer needed to record temperature Careful records must be kept Difficult to use if menstrual cycle is irregular	Must be done by a doctor Effect is permanent—man or woman can never have children after sterilization

CHILDREN LEARN WHAT THEY LIVE

If a child lives with criticism,
he learns to condemn.

If a child lives with hostility,
he learns to fight.

If a child lives with ridicule,
he learns to be shy.

If a child lives with shame,
he learns to feel guilty.

If a child lives with tolerance,
he learns to be patient.

If a child lives with encouragement,
he learns confidence.

If a child lives with praise,
he learns to appreciate.

If a child lives with fairness,
he learns justice.

If a child lives with security,
he learns to have faith.

If a child lives with approval,
learns to like himself.

If a child lives with acceptance and friendship,
he learns to find love in the world.

— Dorothy Law Nolte

BEST COPY AVAILABLE

AM I PARENT MATERIAL?

Some thoughtful questions about one of the most important decisions you'll ever make.

Here are some questions for you to consider before you deal with the important decision of whether or not to have a child.

If you decide to have a child, it'll be a decision that will affect you for the rest of your life. Think about it... Taking responsibility for a new life is awesome.

These questions are designed to raise ideas that you may not have thought about. There are no "right" answers and no "grades"—your answers are "right" for you and may help you decide for yourself whether or not you want to be a parent. Because we all change, your answers to some of these questions may change two, five, even ten years from now.

You do have a choice. Check out what you know and give it some thought. Then do what seems right for you.

Does having and raising a child fit the lifestyle I want?

1. What do I want out of life for myself? What do I think is important?
2. Could I handle a child and a job at the same time? Would I have time and energy for both?
3. Would I be ready to give up the freedom to do what I want to do, when I want to do it?
4. Would I be willing to cut back my social life and spend more time at home? Would I miss my free time and privacy?
5. Can I afford to support a child? Do I know how much it takes to raise a child?
6. Do I want to raise a child in the neighborhood where I live now? Would I be willing and able to move?
7. How would a child interfere with my growth and development?
8. Would a child change my educational plans? Do I have the energy to go to school and raise a child at the same time?
9. Am I willing to give a great part of my life—AT LEAST 18 YEARS—to being responsible for a child? And spend a large portion of my life being concerned about my child's well being?

What's in it for me?

1. Do I like doing things with children? Do I enjoy activities that children can do?
2. Would I want a child to be "like me"?
3. Would I try to pass on to my child my ideas and values? What if my child's ideas and values turn out to be different from mine?
4. Would I want my child to achieve things that I wish I had, but didn't?
5. Would I expect my child to keep me from being lonely in my old age? Do I do that for my parents? Do my parents do that for my grandparents?
6. Do I want a boy or a girl child? What if I don't get what I want?
7. Would having a child show others how mature I am?
8. Will I prove I am a man or a woman by having a child?
9. Do I expect my child to make my life happy?

196